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# MEDICARE QUALITY PROTECTION ACT OF 1986

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## HEARING

SEP 18 1986

BEFORE THE

SUBCOMMITTEE ON HEALTH

U. S. GOVT. PUBS. DEPOSITORY 375

OF THE

## COMMITTEE ON WAYS AND MEANS
## HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

ON

## H.R. 4638

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO ASSURE THE QUALITY OF INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL SERVICES FURNISHED UNDER THE MEDICARE PROGRAM, AND FOR OTHER PURPOSES

APRIL 23, 1986

**Serial 99-75**

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# CONTENTS


| | Page |
|---|---|
| Press release of Friday, April 11, 1986, announcing the hearing | 2 |
| H.R. 4638, text | 3 |

WITNESSES

| | |
|---|---|
| U.S. Department of Health and Human Services, Bartlett Fleming, Acting Deputy Administrator, Health Care Financing Administration, and Philip Nathanson, Director, Health Standards Quality Bureau | 35 |
| Prospective Payment Assessment Commission, Donald A. Young, M.D., Executive Director | 52 |

| | |
|---|---|
| American Association for Continuity of Care, Agnes C. McBroom, R.N | 143 |
| American Association of Retired Persons, John Denning and Jack Christy | 78 |
| American Health Care Association, Paul Willging | 157 |
| American Hospital Association, Jack W. Owen | 85 |
| American Medical Peer Review Association, William Moncrief, Jr., M.D., California Medical Review, Inc | 96 |
| American Nurses' Association, Mary Long, R.N., and Thomas Nickels | 110 |
| American Society for Internal Medicine, F. Warren Tingley, M.D | 101 |
| Blue Cross & Blue Shield Association, Alan P. Spielman and Norma Border | 138 |
| Heinz, Hon. John, a U.S. Senator from the State of Pennsylvania, and Chairman, Special Committee on Aging | 115 |
| National Association for Home Care, Margaret J. Cushman, R.N | 147 |
| National Council of Senior Citizens, Eric Shulman and Janet Myder | 73 |

SUBMISSIONS FOR THE RECORD

| | |
|---|---|
| American Association of Homes for the Aging, statement | 169 |
| American Federation of Home Health Agencies, statement | 173 |
| American Physical Therapy Association, statement | 177 |
| American Speech-Language-Hearing Association, Steven C. White, letter | 179 |
| California Hospital Association, John H. Ferman, letter | 180 |
| Gejdenson, Hon. Sam, a Representative in Congress from the State of Connecticut, letter | 181 |
| National Committee to Preserve Social Security and Medicare, Hon. James Roosevelt, statement | 182 |
| Roybal, Hon. Edward R., a Representative in Congress from the State of California, and chairman, Select Committee on Aging, statement | 185 |

# MEDICARE QUALITY PROTECTION ACT OF 1986

WEDNESDAY, APRIL 23, 1986

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:30 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing, and a copy of the bill, H.R. 4638, follow:]

FOR IMMEDIATE RELEASE
FRIDAY, APRIL 11, 1986

PR #10
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING
ON A MEDICARE PATIENT PROTECTION PROPOSAL
TO BE HELD WEDNESDAY, APRIL 23, 1986

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on legislation that addresses the issue of quality of care under the medicare program. The hearing, which will focus on the Medicare Quality Assurance Act of 1986, will begin at 10:00 a.m. on Wednesday, April 23, 1986, in room B-318 Rayburn House Office Building.

Continuing emphasis on cost containment has led to growing concern that quality of care could be compromised as a result of these efforts. Attention has focused on the possibility that some patients are being discharged from hospitals too quickly and that post-hospital care is not always adequate.

Chairman Stark and Senate Aging Committee Chairman John Heinz (R., Pa.) address these concerns in a bill they will introduce next week, "The Medicare Quality Assurance Act of 1986," which would:

-- require the Department of Health and Human Services to come up with a plan to refine the existing hospital payment system by 1988 so that payments would better account for severity and complexity of illness.

-- require hospitals to give patients a written statement of rights, including the right to appeal a decision by the hospital to discharge the patient.

-- bar the hospital from billing the patient for charges incurred within three days of such a challenged discharge. The relevant peer review organization would have to decide the issue within that time.

-- prohibit hospitals from rewarding physicians for meeting specific length-of-stay or cost-of-care targets.

-- extend the waiver of liability to "technical" denials for home health care.

-- allow providers to bring appeals on behalf of beneficiaries and allow appeals of "technical" denials.

-- require peer review organizations to investigate patient complaints about the quality of care.

The legislation contains a number of other provisions to assure quality of care and to improve access to appropriate post-hospital care.

"There is a natural tension between containing costs and maintaining quality," said Chairman Stark in announcing the hearing. "Senator Heinz and I think it is time to balance the budget debate with provisions to protect quality."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statment for the printed record of the hearing, six copies are required and must be submitted by the close of business on Friday, May 9, 1986, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

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99TH CONGRESS
2D SESSION

# H. R. 4638

To amend title XVIII of the Social Security Act to assure the quality of inpatient hospital services and post-hospital services furnished under the medicare program, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

APRIL 17, 1986

Mr. STARK (for himself, Mr. GRADISON, Mr. WAXMAN, Mr. ROYBAL, Mr. PEPPER, Mr. JACOBS, Mr. RANGEL, Mr. DONNELLY, Mr. COYNE, Mr. PICKLE, Mr. DAUB, Mr. GREGG, Mr. RINALDO, and Mr. REGULA) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

---

# A BILL

To amend title XVIII of the Social Security Act to assure the quality of inpatient hospital services and post-hospital services furnished under the medicare program, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the "Medicare Quality Protection Act of 1986".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY ASSURANCE IN INPATIENT HOSPITAL SETTINGS

Sec. 101. Refinement of prospective payment system.
Sec. 102. Requiring notice of hospital discharge rights.
Sec. 103. PRO review of hospital denial notices.
Sec. 104. Prohibition of certain physician incentive plans.
Sec. 105. Review of standards for medicare conditions of participation for assuring quality of inpatient hospital services.
Sec. 106. Study of payment for administratively necessary days.

TITLE II—ACCESS TO APPROPRIATE POST-HOSPITAL CARE

Sec. 201. Requiring hospitals to provide discharge planning process.
Sec. 202. Extension of waiver of liability provisions to certain coverage denials for home health services.
Sec. 203. Continuing favorable presumption of waiver of liability for skilled nursing facilities and home health agencies.
Sec. 204. Development of uniform needs assessment instrument.
Sec. 205. Expedited review by fiscal intermediaries.
Sec. 206. Prompt response to inquiries concerning exhaustion of medicare skilled nursing facility benefit.
Sec. 207. Provider representation of beneficiaries on appeals and permitting appeal of certain technical denials.
Sec. 208. Including in annual reports on prospective payment system information on quality of post-hospital care.

TITLE III—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

Sec. 301. PRO review of inpatient hospital services and early readmission cases.
Sec. 302. Requiring PRO review of quality of care.
Sec. 303. Requiring consumer representative on peer review boards.
Sec. 304. Improving peer review responsiveness to beneficiary complaints.
Sec. 305. Sharing of information by peer review organizations.

TITLE IV—STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE

Sec. 401. Study to develop a strategy for quality review and assurance.

# TITLE I—QUALITY ASSURANCE IN INPATIENT HOSPITAL SETTINGS

### SEC. 101. REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM.

(a) DEVELOPMENT OF LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop and submit to Congress a specific legislative proposal to improve the classification and payment system under section 1886(d)

of the Social Security Act (and, as appropriate, the system for payment of outliers under section 1886(d)(5)(A) of such Act) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

(b) ACCOUNTING FOR SEVERITY OF ILLNESS.—In developing the proposal, the Secretary shall account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(c) DEADLINE.—The proposal shall be submitted to Congress by not later than January 1, 1988.

**SEC. 102. REQUIRING NOTICE OF HOSPITAL DISCHARGE RIGHTS.**

(a) REQUIREMENT FOR HOSPITALS TO PROVIDE STATEMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by sections 9121(a), 9122(a), and 9403(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended—

(1) by striking "and" at the end of the subparagraph (I) inserted by section 9121(a) of such Act,

(2) by striking the period at the end of subparagraph (J) and inserting a comma,

(3) by redesignating the subparagraph (I) inserted by section 9403(b) of such Act as subparagraph (K) and by inserting it after subparagraph (J), and

(4) by inserting after subparagraph (K) the following new subparagraph:

"(L) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a legally responsible person or persons acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

"(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

"(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

"(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

"(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal."

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(L) of the Social Security Act not later than six months after the date of the enactment of this Act. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.

**SEC. 103. PRO REVIEW OF HOSPITAL DENIAL NOTICES.**

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c-3) is amended by adding at the end the following new subsection:

"(d)(1) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

"(B) the attending physician has agreed with the hospital's determination,

the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

"(2) If—

"(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

"(B) the attending physician has not agreed with the hospital's determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital's determination.

"(3) If a patient (or a patient's representative)—

"(A) has received a notice under paragraph (1), and

"(B) while the patient is still an inpatient in the hospital, requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital's determination and shall provide notice (by telephone and in writing) to the patient or representative of the results of the review not later than 2 calendar days after the date the organization receives the request. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or the patient will be liable for payment for such continued care.

"(4) If—

"(A) a request is made under paragraph (3) not later than 1 day after the date the patient (or patient's

representative) receives the notice under paragraph (1), and

"(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met, the hospital may not charge the patient for inpatient hospital services furnished on a day before the fourth day that begins after the date of receipt of the notice under paragraph (1).

"(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative)."

(b) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to denial notices furnished by hospitals to individuals on and after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

(2) Section 1154(d)(4) of the Social Security Act (as added by the amendment made by subsection (a)) shall take effect on the date of the enactment of this Act.

**SEC. 104. PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS.**

(a) MAKING CERTAIN PLANS SUBJECT TO CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

(1) by striking "subsection (a)" each place it appears and inserting "subsection (a) or (b)",

(2) in subsection (f), by striking "subsection (d)" and inserting "subsection (e)",

(3) by redesignating subsections (b) through (h) as subsections (c) through (i), respectively, and

(4) by inserting after subsection (a) the following new subsection:

"(b)(1) If—

"(A) a hospital makes a payment, directly or indirectly, to a physician as an inducement to reduce the length of stay or services provided with respect to an identifiable patient (who is entitled to benefits under part A of title XVIII), and

"(B) the payment is based on a specific length of stay or targeted amount of services with respect to the patient,

the hospital shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of twice the amount of the payment plus an amount of not more than $2,000 for each patient with respect to which the payment is made.

"(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of twice the amount of the payment

plus an amount of not more than $2,000 for each patient with respect to which the payment is made."

(b) STUDY OF ADDITIONAL SANCTIONS.—The Secretary of Health and Human Services shall develop and report to Congress, not later than July 1, 1987, on specific legislative changes that should be made to prohibit other physician incentive plans that have the effect of pressuring physicians improperly to discharge patients from hospitals before their discharge is medically appropriate or to reduce medically appropriate services.

**SEC. 105. REVIEW OF STANDARDS FOR MEDICARE CONDITIONS OF PARTICIPATION FOR ASSURING QUALITY OF INPATIENT HOSPITAL SERVICES.**

The Secretary of Health and Human Services shall arrange for a study the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation under title XVIII of the Social Security Act, in assuring the quality of services furnished in the hospitals. The Secretary shall report to Congress on the results of the study by not later than 2 years after the date of the enactment of this Act.

**SEC. 106. STUDY OF PAYMENT FOR ADMINISTRATIVELY NECESSARY DAYS.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study—

(1) to determine—

(A) the extent to which costs of hospitals attributable to administratively necessary days have been incorporated into payments under section 1886(d) of the Social Security Act, and

(B) to the extent they have been, the extent to which the distribution among hospitals of payments under such section relating to such costs actually reflects such hospitals' costs for administratively necessary days; and

(2) to determine whether a payment should be made (in a budget-neutral manner under title XVIII of such Act to hospitals receiving payments under section 1886(d) of such Act) to a hospital for administratively necessary days, separate from the per-discharge and outlier payments made under such section.

(b) ADMINISTRATIVELY NECESSARY DAYS DEFINED.—In this section, an "administratively necessary day" is a day of continued inpatient hospital stay, for an individual entitled to benefits under part A of title XVIII of the Social Security Act, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

(c) CONSIDERATIONS IN CONDUCTING STUDY.—In conducting the study, the Secretary shall consider—

(1) the need for such a payment in order to minimize—

(A) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to diffculties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care, and

(B) the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility, and

(2) the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(d) REPORT ON STUDY.—The Secretary shall report to Congress on the results of the study not later than January 1, 1988.

# TITLE II—ACCESS TO APPROPRIATE POST-HOSPITAL CARE

## SEC. 201. REQUIRING HOSPITALS TO PROVIDE DISCHARGE PLANNING PROCESS.

(a) REQUIREMENT AS CONDITION OF PARTICIPATION.—Section 1861(e)(6) of the Social Security Act (42 U.S.C. 1395x(e)(6)) is amended—

(1) by inserting "(A)" after "(6)", and

(2) by inserting before the semicolon at the end the following: "and (B) has in place a discharge planning process that meets the requirements of subsection (ee)".

(b) DISCHARGE PLANNING PROCESS.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

"DISCHARGE PLANNING PROCESS

"(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to insurance benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

"(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

"(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

"(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

"(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

"(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

"(E) The results of a discharge planning evaluation must be made available to the patient (or the patient's representative) and the patient's physician for use in establishing an appropriate discharge plan.

"(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

"(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel."

(c) EFFECT OF ACCREDITATION.—The second sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended—

(1) by inserting ", requires a discharge planning process (or imposes another requirement which services

substantially the same purpose)," after "the same purpose)", and

(2) by inserting "clause (A) or (B) of" after "comply also with".

(d) EFFECTIVE DATE.—The requirements of section 1861(ee) of the Social Security Act shall apply to agreements entered into with hospitals, under section 1866 of the Social Security Act, on or after one year after the date of the enactment of this Act.

**SEC. 202. EXTENSION OF WAIVER OF LIABILITY PROVISIONS TO CERTAIN COVERAGE DENIALS FOR HOME HEALTH SERVICES.**

(a) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended—

(1) in subsection (a)(1), by inserting "or by reason of a coverage denial described in subsection (f)" after "section 1862(a)(1) or (9)";

(2) in the first sentence of subsection (a), by inserting "and as though the coverage denial described in subsection (f) had not occurred" before the period at the end;

(3) in the third sentence, by inserting "or by reason of a coverage denial described in subsection (f)" after "section 1862(a)(1) or (9)";

(4) in subsection (c), by inserting "or by reason of a coverage denial described in subsection (f)" after "section 1862(a)(1) or (9)"; and

(5) by adding at the end the following new subsection:

"(f) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in that the individual—

"(1) is or was not confined to his home, or

"(2) does or did not need skilled nursing care on an intermittent basis or physical, speech, or occupational therapy."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to coverage denials occurring on or after the first day of the first month that begins more than 90 days after the date of the enactment of this Act.

SEC. 203. CONTINUING OF FAVORABLE PRESUMPTION OF WAIVER OF LIABILITY FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp), as amended by section 202, is further amended by adding at the end the following new subsection:

"(g)(1)(A) A skilled nursing facility which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a)(1) or (9).

"(B) A home health agency which meets the applicable requirements—

"(i) of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to denials of coverage by reason of section 1862(a)(1) or (9), and

"(ii) of paragraphs (3) and (5) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (f).

"(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

"(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

"(B) In the case of a skilled nursing facility, the committee or group responsible for the conduct of utilization review for the facility has informed the facility

that payment may not be made under this title with respect to the services.

"(C) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

"(3) The requirements of this paragraph are as follows:

"(A) The facility or agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

"(B) The facility or agency has reasonable procedures to notify promptly each patient (and the patient's physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

"(4) The requirement of this paragraph is that, on the basis of bills submitted by the facility or agency during the previous quarter, the rate of denial of bills by reason of section 1862(a)(1) or (9) for the facility or agency does not exceed—

"(A) 5 percent, in the case of skilled nursing facilities computed based on days of post-hospital extended care services care covered, or

"(B) 2.5 percent, in the case of home health agencies computed based on visits for home health services covered.

"(5) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (f) does not exceed 2.5 percent, computed based on visits for home health services covered.

"(6) The Secretary, annually, shall report to Congress—

"(A) information on the frequency and distribution (by types of providers) of denials referred to in paragraphs (4) and (5), including—

"(i) the reasons for such denials,

"(ii) the extent to which payments were nonetheless made because of this section, and

"(iii) the rate of reversals of such denials, and

"(B) such other information as may be appropriate to evaluate the appropriateness of the percentage standards established under such paragraphs (4) and (5).

"(7) In this subsection, the term 'fiscal intermediary' means, with respect to a skilled nursing facility or home

health agency, an agency or organization with an agreement under section 1816 with respect to the facility or agency and includes, with respect to a home health agency, a carrier with a contract under section 1842 with respect to the agency."

(b) REPEALING DUPLICATIVE PROVISIONS.—Section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985, and subsection (c) of section 9126 of such Act, are repealed.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to services for which a notice of coverage denial (described in section 1879(f) of the Social Security Act) is made on or after the first day of the first calendar quarter that begins at least 90 days after the date of the enactment of this Act.

SEC. 204. DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.

(a) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that—

(1) evaluates—

(A) the functional capacity of an individual,

(B) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and

(C) the social and familial resources available to the individual to meet those requirements; and

(2) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

(b) ADVISORY PANEL.—The Secretary shall develop the instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and representatives of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(c) REPORT ON INSTRUMENT.—The Secretary shall report to Congress, not later than 1 year after the date of the enactment of this Act, on the instrument developed under this section. The report shall include an evaluation of the advantages and disadvantages of using the instrument as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to individuals entitled to benefits under part A of title XVIII of the Social Security Act.

**SEC. 205. EXPEDITED REVIEW BY FISCAL INTERMEDIARIES.**

(a) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp), as amended by sections 202 and 203 of this title, is further amended by adding at the end the following new subsection:

"(h) The Secretary shall develop procedures to expedite the determination of whether initial claims submitted for post-hospital extended care services and home health services provided (or to be provided) to an individual may be reimbursed under this title, so as to minimize the time between (1) when the provider first provides the services to the individual, and (2) when the provider first receives notice of an initial determination on whether or not payment may be made under this title for some or all of the services provided the individual."

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall provide for the expedited procedures described in section 1879(h) of the Social Security Act not later than one year after the date of the enactment of this Act.

**SEC. 206. PROMPT RESPONSE TO INQUIRIES CONCERNING EXHAUSTION OF MEDICARE SKILLED NURSING FACILITY BENEFIT.**

The Secretary of Health and Human Services shall provide, in the administration of part A of title XVIII of the Social Security Act and by not later than 9 months after the

date of the enactment of this Act, for a response within 24 hours to any inquiry by a beneficiary (and to any inquiry by a hospital or skilled nursing facility with the beneficiary's consent) to the Secretary concerning whether the beneficiary's benefits under section 1812(a)(2) of such Act (relating to post-hospital extended care services) have been exhausted.

**SEC. 207. PROVIDER REPRESENTATION OF BENEFICIARIES ON APPEALS AND PERMITTING APPEAL OF CERTAIN TECHNICAL DENIALS.**

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item.".

(b) PERMITTING REVIEW OF TECHNICAL DENIALS.—Section 1869 of such Act is further amended—

(1) in subsection (a), by inserting ", the amount of benefits with respect to home health services under part B, and any other determination with respect to a claim for benefits under part A" after "part A,", and

(2) in subsection (b)(1)—

(A) by striking "or" at the end of subparagraph (B),

(B) by inserting ", or" at the end of subparagraph (C), and

(C) by inserting after subparagraph (C) the following new subparagraph:

"(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,".

(c) EFFECTIVE DATE.—The amendment made by this section take effect on the date of the enactment of this Act.

SEC. 208. INCLUDING IN ANNUAL REPORTS ON PROSPECTIVE PAYMENT SYSTEM INFORMATION ON QUALITY OF POST-HOSPITAL CARE.

(a) IN GENERAL.—Section 603(a)(2) of the Social Security Amendments of 1983 is amended—

(1) by striking "1987" in subparagraph (A) and inserting "1989", and

(2) by adding at the end the following new subparagraph:

"(E) In each annual report to Congress under subparagraph (A), the Secretary shall include—

"(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act,

"(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

"(iii) information on reconsiderations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services."

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply to reports for years beginning with 1986.

# TITLE III—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

## SEC. 301. PRO REVIEW OF INPATIENT HOSPITAL SERVICES AND EARLY READMISSION CASES.

(a) TIMELY PROVISION OF HOSPITAL INFORMATION.—Section 1153 of the Social Security Act (42 U.S.C. 1320c-2) is amended by adding at the end the following new subsection:

"(g) The Secretary shall provide that peer review organizations receive, each month on a timely basis, data from

hospitals necessary to initiate the review process under section 1154(a) on a timely basis."

(b) REQUIRING REVIEW OF EARLY READMISSION CASES.—Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by section 9401(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

"(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an 'early readmission case' is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge."

(c) EFFECTIVE DATES.—(1) The Secretary shall implement the amendment made by subsection (a) not later than 6 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to contracts entered into or renewed on or after January 1, 1987.

SEC. 302. REQUIRING PRO REVIEW OF QUALITY OF CARE.

(a) ALLOCATION OF FUNDS FOR QUALITY CARE REVIEW.—Section 1154(a)(4) of the Social Security Act (42 U.S.C. 1320c-3(a)(4)) is amended by adding at the end the following: "Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations) for which potential problems of quality have been identified.".

(b) IDENTIFICATION OF METHODS FOR IDENTIFYING CASES OF SUBSTANDARD CARE.—Section 1154 of such Act (42 U.S.C. 1320c-3), as amended by section 103(a) of this Act is amended by adding at the end the following new subsection:

"(e) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care."

(c) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to contracts entered into or renewed on or after January 1, 1987.

(2) The amendment made by the subsection (b) becomes effective on the date of the enactment of this Act.

**SEC. 303. REQUIRING CONSUMER REPRESENTATIVE ON PEER REVIEW BOARDS.**

(a) IN GENERAL.—Section 1152 of the Social Security Act (42 U.S.C. 1320c-1) is amended—

(1) by striking "and" at the end of paragraph (1),

(2) by striking the period at the end of paragraph (2) and inserting "; and", and

(3) by adding at the end the following new paragraph:

"(3) has at least one individual who is a representative of consumers on its board of directors."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contracts entered into or renewed on or after January 1, 1987.

**SEC. 304. IMPROVING PEER REVIEW RESPONSIVENESS TO BENEFICIARY COMPLAINTS.**

(a) APPROPRIATE INVESTIGATION OF COMPLAINTS REQUIRED.—Section 1154(a) of the Social Security Act (42 U.S.C. 1320c-3(a)), as amended by section 301(a) of this title, is further amended by adding at the end the following new paragraph:

"(14) The organization shall conduct an appropriate investigation of all written complaints about the

quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). The fact that such a complaint is made and the name of the complainant shall be treated as confidential. The organization shall inform the individual (or representative) of the organization's findings respecting the complaint."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to complaints received on or after the first day of the first month that begins at least 9 months after the date of the enactment of this Act.

**SEC. 305. SHARING OF INFORMATION BY PEER REVIEW ORGANIZATIONS.**

(a) IN GENERAL.—Section 1160(b)(1) of the Social Security Act (42 U.S.C. 1320c-9(b)(1)) is amended—

(1) in subparagraph (C), by striking "is required" and inserting "are required",

(2) by striking "and" at the end of subparagraph (B), and

(3) by adding at the end the following new subparagraph:

"(D) to assist—

"(i) national accreditation bodies which are acting, pursuant to section 1865, in accrediting providers for purposes of meeting the conditions described in provisions in title XVIII, and

"(ii) State ombudsmen and State protection and advocacy officials who the Secretary identifies as having responsibility for assuring the quality of care furnished by providers or practitioners,

which data and information shall be provided by the peer review organization to any such body, ombudsman, or official upon request relating to a specific provider or practitioner, but only to the extent that such data and information are related to the quality of care furnished by a provider or practitioner and only if the peer review organization determines that the data and information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care, and that the data and information are needed by the body, ombudsman, or official in carrying out official duties;".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act.

# TITLE IV—STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE

## SEC. 401. STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care for which payment may be made under title XVIII of the Social Security Act (the medicare program).

(b) ITEMS INCLUDED IN STUDY.—Among other items, the study shall—

(1) identify the appropriate considerations which should be used in defining "quality of care";

(2) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(3) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done;

(4) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(5) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(6) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(7) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and

(8) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(c) REPORT.—The Secretary shall submit to Congress, not later than 2 years after the date of the enactment of this Act, a report on the study. Such report shall address the items described in subsection (b) and shall include recommendations with respect to strengthening quality assurance and review activities for services furnished under the medicare program.

(d) CONSULTATION IN STUDY.—In developing plans for the conduct of the study, the Secretary shall assure that consumer and provider groups, peer review organizations, the

Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring of the quality of care are consulted.

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Chairman STARK. General courtesy would indicate that I wait for one of the members of the minority, but in the interest of moving the hearing along a little bit, I am sure that they will forgive me for starting with my opening statement, which I am sure they will be happy to miss as a matter of fact. I will proceed with that, and the committee will proceed. We might hold off a minute at the conclusion of that.

Patient protection is our aim today as we begin consideration of legislation that would send a message to Medicare providers that their efforts to cut costs don't mean that they can compromise on quality or access.

We are specifically considering a bill that several of us introduced last week in response to reports that Medicare beneficiaries were being discharged from hospitals before it was medically appropriate and not getting needed posthospital care.

Clearly, there have been some excesses in the drive for greater efficiency. This bill is an attempt to provide some balance.

Patients tell us that they are being checked out of the hospital when they still require care.

Physicians report that they are being pressured by hospital administrators to discharge patients early.

Yet peer review organizations have received relatively few reports of such activity.

Our hope is that this legislation will send a clear message to all concerned about what their responsibilities are. We want to let patients know that they do have recourse if they feel they are being treated improperly. And we want to put providers on notice that compromising on quality is not an acceptable cost-cutting strategy.

Our first witness was scheduled to be Senator Heinz from Pennsylvania. I am informed that he is at the White House. I will therefore ask Mr. Fleming, the Acting Deputy Administrator of the Health Care Financing Administration from the Department of Health and Human Services, if he would like to proceed at this time with his testimony. We will hold off for questioning later. He is accompanied by Mr. Philip Nathanson, Director, Health Standards Quality Bureau of HCFA.

Welcome to the committee again, your full testimony will appear in the record in its entirety. While I don't generally put a time restriction on the administration, I might ask if you would care to summarize your testimony this morning, and we will let you expand on it during the questioning period.

**STATEMENT OF BARTLETT FLEMING, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY PHILIP NATHANSON, DIRECTOR, HEALTH STANDARDS QUALITY BUREAU, HCFA**

Mr. FLEMING. Thank you very much, Mr. Chairman. We are pleased to be here, equally concerned with you and your cosponsors on this legislation over the issue of quality of care. I am going to submit my remarks in their entirety for the record, and just make a preliminary comment.

The administration does not take the issue of quality of care in Medicare lightly, and as I said, we truly appreciate your concern and your efforts to address this area of mutual concern.

Mr. Chairman, we had hoped to have testimony reflecting an accurate reading of our reaction to your bill. However, we were notified of this hearing about 2 weeks ago. There has only been one preliminary meeting with staff. We received the final copy of this legislation just last Wednesday. There has not been adequate opportunity for the administration to examine this bill, to get into its parts and then look at it in its context as a whole.

In the interests of working closely with you and your committee on this important issue, though, we did agree to participate in the hearing, I hope you will bear this in mind as we proceed. I assure you we will take every step to provide you with a comprehensive response to the issues and to the provisions of the bill.

[The statement of Mr. Fleming follows:]

STATEMENT OF BARTLETT FLEMING, ACTING DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH

INTRODUCTION

Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss our activities in the area of preserving the high quality of care afforded Medicare beneficiaries. We share this Committee's interest in assuring that Medicare is achieving its goal of providing high quality services that are both medically necessary and appropriate, and in assuring that efforts to contain costs are not adversely affecting Medicare beneficiaries. I would especially like to commend your efforts, Mr. Chairman, and those of Senator Heinz, to augment the Health Care Financing Administration's authority to achieve these goals. We join with you in the effort to assure that the care provided to Medicare beneficiaries is of the highest quality, and look forward to working with you to advance that goal.

Before I begin, I would like to comment briefly on the provisions of H.R. 4638, The Medicare Quality Protection Act of 1986. As I indicated, we are strongly committed to the goal of high quality care, and have expanded our activities in this area, both through our research program and the Peer Review Organizations (PROs). Many of the provisions included in H.R. 4638 indeed include approaches to quality currently underway or being considered by HCFA. Other provisions represent significant departures, some of which appear to be potentially costly expansions. Quality of care is among our highest priorities, and we believe that H.R. 4638 deserves careful analysis and our full attention. Since the bill was introduced only a week ago, we have been unable to give H.R. 4638 the careful attention it deserves, but will share the results of our analysis as soon as it is completed.

I would like to describe the activities we are currently undertaking to assure the quality of care provided to Medicare beneficiaries.

QUALITY OF CARE

High quality medical care has a long-standing tradition in this nation. The Medicare program has played an important role by ensuring that high quality services are available to older Americans. Over the past several years, Congress and this Administration have had to face some tough facts, including the fact that health care costs in general and the cost of the Medicare program in particular were spiraling upward at a tremendous rate. In passing legislation to reform the Medicare hospital reimbursement system in 1983, Congress confronted the task of slowing this trend head-on, and in doing so, presented an enormous challenge to our Department in the implementation of the prospective payment system. We are well into the third year under PPS, and continuing refinement of PPS remains a priority.

One of the most crucial objectives throughout the payment reform process has been to maintain the quality of and access to care for our beneficiaries. We recognized, as did Congress, that the potential for problems in quality of care would also exist under PPS. This concern, in part, motivated the Congress to create the Peer Review Organizations (PROs). But the implementation of PROs was just the beginning. Just as we continue to monitor and refine the PPS to ensure that payment levels support delivery of high quality care, we must also continue to monitor and refine the PRO quality assurance program. This medical review system is a complex, dynamic system and we have learned a lot during the first two years of PRO review. We are using this experience to refine PRO review in order to assure that Medicare beneficiaries continue to receive high quality, medically necessary care in the appropriate setting.

PRO SCOPE OF WORK

So, what did we learn during the first PRO contract period and how are we using this knowledge to assure quality of care? Briefly, we learned that we needed:

- To redefine PRO efforts in all areas of quality review;
- To more aggressively address the possibility of premature discharge;
- To further focus PRO review on poor performing providers and practitioners; and
- To expand our efforts to assure that beneficiaries and their families understand their rights.

And we have aggressively addressed each of these issues. We have expanded

the PRO's Scope of Work for the 1986-1988 contract period to require PROs to subject every case they review to a computer-based screen to determine such things as the adequacy of discharge planning, medical stability at discharge, the presence of nosocomial infections and trauma suffered in the hospital.

PROs will continue to focus on transfers to other hospitals and exempt units to identify problems with inappropriate or unnecessary transfer. Review of readmissions has also been expanded to require review of all readmissions within 15 days of discharge as opposed to within 7 days as required in the first PRO contract period.

In all cases where a PRO finds poor quality, corrective action will be taken, ranging from education of the individual physician or hospital, to intensified review, to payment denials and ultimately to exclusion from the Medicare program. Provisions in COBRA expanding the PROs' authority to deny payment for poor quality care will further increase the effectiveness of PROs. Our Inspector General has recently made recommendations to us and we are working with him and his staff to make necessary changes.

A continuing concern of both Congress and the Administration has been the potential for premature discharge under PPS. We share this concern. The Medicare program emphasizes that patients should remain in the hospital until they are well enough to be released. We do know that there have been cases of premature discharge and we will investigate each case and take appropriate action. Even one case of premature discharge is unacceptable to this Administration and we are committed to the strongest possible action, based on the circumstances of each case, when we learn of any instances of poor quality care. To augment our current authority, COBRA provides us with additional authority to take action against hospitals that inappropriately discharge or transfer Medicare beneficiaries. Towards this end, we forwarded to the Congress last year a draft bill, the "Health Care Financing Amendments of 1985," which includes language to allow exclusion of providers for failing to meet standards of care. We were pleased to see this language included in the Committee's version of the bill, H.R. 1868.

PATIENT'S RIGHTS

Another area that has concerned us is the continuing misleading by some providers about PPS, PRO review and the rights of patients to an appeal. We continue to hear from Medicare beneficiaries and their families that they are being told that a patient must be discharged from the hospital once the "DRG is up" or because their "Medicare days are up." Clearly, this is not the case. The PPS system is based on payments which, on average for a DRG, will be adequate to cover the utilization of services. Some patients will have stays below the average, others above it. It is the responsibility of the hospital to provide all necessary services regardless of the length of stay.

In order to increase beneficiary understanding of this fact, we have instructed all hospitals to give beneficiaries information upon admission about their appeal rights. In late February, a letter "An Important Message From Medicare" was provided to all fiscal intermediaries for distribution to Medicare providers who must give it to beneficiaries upon admission. We have instructed PROs to monitor hospital compliance with the distribution of this information to beneficiaries.

In addition to this beneficiary letter, we are revising and consolidating the pamphlets which explain the appeals provisions under Medicare. We are also developing a new pamphlet to better educate Medicare beneficiaries and their families regarding hospital stays under PPS. The 1986 edition of Your Medicare Handbook has already been revised to include additional current information on a number of relevant topics, including appeal rights, PPS and the role of the PRO. We have issued "Medicare/Medicaid Notes" to beneficiary groups to explain, among other topics, PPS and their appeal rights. We are also providing these "Notes" to the Administration on Aging for distribution to their Area Agencies on Aging.

Finally, we have included in the 1986-1988 PRO scope of work a community outreach program to help beneficiaries understand the role of the PRO and their appeals rights. We will also continue to work with groups interested in developing informational publications on the appeals process. We will continue to use every avenue available to us to assist our beneficiaries in becoming their own best advocate.

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We also have many research activities in the area of quality. One of these studies, being conducted by our Office of Research and Demonstrations, is to detect the broad PPS-related effects on quality of care by examining the outcomes of hospital care on the health status of patients.

We have contracted with health care research firms for completion of four others:

- A study by the Commission on Professional and Hospital Activities to measure the general effects of PPS on the quality of inpatient hospital care, primarily by examining changes in hospital usage and treatment patterns and their effects on inpatient and discharge status;
- Two studies by Rand Corporation:
  - A study to evaluate the impact of PPS on the quality of care by assessing potential effects on changes in inpatient hospital treatment patterns through a thorough examination of the medical record, and resultant health status outcomes; and
  - A study to develop improved methods for monitoring hospitals on an ongoing basis.
- A study by the Urban Institute to evaluate PPS quality impacts on ESRD Medicare beneficiaries, a subset of the Medicare population generally assumed to represent an unusually high medical risk group.
- A study by Duke University and the Urban Institute of changes brought about by PPS on the use of Medicare services by the chronically impaired elderly, a sub-population who may be in particular need of post discharge services.

Additional quality of care studies include:

- A study by the Northwest Oregon Health Systems, currently underway, to develop a method for measuring patient health status at the time of hospital discharge. This study will help us understand the functional status of patients at discharge and give us some insight into the type of patients who may require post-hospital care and the level of this need. While the instrument is not intended as a patient management tool, it may ultimately be used to determine the impact of PPS on the health status of patients at discharge, and;
- A major study is also being planned by HCFA, in coordination with Assistant Secretary for Planning and Evaluation (ASPE), to determine the need for post-hospital services and the availability of these services. This study would look at the appropriateness of post-hospital care services, potential barriers to these services, program and benefit costs as well as out-of-pocket costs for beneficiaries.

We expect that these quality studies will provide needed information on the actual impact of PPS on patient health status and how PRO review should be further refined.

## CONCLUSION

We share the same goal, Mr. Chairman, that of assuring that every Medicare patient receives high quality, medically necessary care. We look forward to our continued cooperation in achieving this shared goal. I will be happy to answer any questions.

ADDENDUM

We share the Committee's commitment to maintaining the quality of medical care provided to Medicare beneficiaries. We look forward to working with you to address the concern that has arisen in this area.

This presents more fully the Administration's views on H.R. 4619: the "Medicare Quality Protection Act of 1986." In summary, we oppose many of the provisions of the bill because:

- Many of the provisions dealing with quality are being or could be accomplished under current legislative authority;
- They would result in expansion of program benefits; or
- They would result in increased administrative expenditures and add to an already enormous burden of mandated studies.

We have the following comments on each section:

Section 101: Refinement of prospective payment system (Studies)

We believe this provision, requiring the Secretary to submit to Congress by January 1, 1988, a legislative proposal to assure that the amount paid per discharge under the prospective payment system would approximate the cost of medically necessary care for individual patients or classes of patients with similar conditions is unnecessary.

We now take into account data needed to approximate the cost of medically necessary care for classes of patients with unique conditions through the use of diagnostic related groups (DRGs), and have outlier payment provisions for extremely long or high cost cases. DRGs are calculated from the pieces of information available through the Uniform Hospital Discharge Data Set. As its name implies, this information is prepared by hospitals in conjunction with each discharge and is used to determine into which DRG a discharge falls. We believe that the DRG approach provides the best possible groupings using current, national data.

Building better measures of severity requires information that is not systematically captured in most hospitals and currently does not exist in national data sets. Because of the interest in this area, we are actively pursuing several avenues to fill this information gap and have funded significant amounts of research in this area. However, the research community is far from consensus about what variables, in what combination, represent patient differences which should be recognized in a payment system. We do not believe, therefore, that such data can be collected and analyzed and the needed consensus reached in the time proposed. We are committed to maintaining the necessary research emphasis to answer the question of whether severity of illness data can better account for case complexity than the current system.

Section 102: Requiring notice of hospital discharge rights (Quality)

We agree that discharge rights are an important area in protecting beneficiaries. We have provided a letter, "An Important Message From Medicare," to all intermediaries for distribution to Medicare hospitals. These providers, in turn, assure that every Medicare beneficiary admitted to their institution receives a copy and PROs will monitor the hospitals' compliance with this requirement. In addition, we are working with the Social Security Administration and the Administration on Aging to assure that beneficiaries know they are to get this message. This is one part of our overall

effort to assure that Medicare beneficiaries are aware of their rights.

Although we do not currently require hospitals to issue any notice discussing a patient's "rights to post-hospital care," we have no objection to requiring hospitals to provide beneficiaries with information such as that included in The Medicare Handbook, which spells out benefits to which Medicare beneficiaries are entitled. This may also be accomplished under current authority, and we are willing to work with the Committee to make changes.

Section 103: PRO review of hospital denial notices (Quality)

We agree that the inconsistencies between the time allowed PROs to review and time in which a patient becomes liable should be resolved. We believe the Bill's goal can be achieved in a more cost-effective manner under our administrative authority. We question whether this provision is the most cost effective way of improving the situation since it would substantially increase PRO program costs by requiring PROs to staff offices 7 days a week in the event they received a request for review.

Section 104: Prohibition of certain physician incentive plans

This provision would make certain hospital physician incentive plans subject to civil monetary penalties. We have no position on this amendment at this time. We understand the concern underlying this amendment: that the PPS system is designed to encourage hospitals to be cost effective, delivering only those services which are medically necessary. This incentive also encourages hospitals to discharge patients when they no longer need acute hospital care. Some hospitals may respond to this "incentive" by discharging patients prematurely. We are focusing PRO review on this issue in several ways, e.g., review of readmissions within 15 days, review of discharge planning to assure the discharge was appropriate and imposition of sanctions when appropriate.

The Department is scrutinizing capitation approaches and believes this provision could unnecessarily hamper positive development in this area. We would be happy to work with the Committee to develop legislation to meet both objectives.

Section 105: Review of standards for Medicare conditions of participation for assuring quality of inpatient hospital services.

We oppose this provision which would require a study of the current hospital regulatory conditions of participation. It is widely accepted by the Department and the industry that these conditions need to be revised. New conditions of participation which focus on outcomes of care are currently in the final stages of clearance and we expect they will be published shortly.

Section 106: Study of payment for administratively necessary days

We believe this provision to be unnecessary. Administratively necessary days are days of continued inpatient hospital stay necessitated by a delay in obtaining placement for an individual in a skilled nursing facility. Payment for these days is built into the PPS base and is included in the DRG payments for such days that fall within the outlier threshold. Per diem payments are made when they occur beyond the outlier threshold.

This provision, however, appears to be motivated by the concern

that:

- Reduced hospital length of stay may, in some cases, lead to increased need for skilled nursing facility (SNF) care; and,
- Uneven availability of SNF beds across states may result in the unavailability of needed post-hospital acute care services.

HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) are currently exploring a study to determine the appropriate methods for addressing these issues. This is a totally new area of investigation and thus, there are no agreed upon measures. We believe that this study will answer the larger question of which administratively necessary days are only a part.

**Section 201:** Requiring hospitals to provide discharge planning process

We agree that appropriate coordination of discharge planning is essential to total patient care and that this is a function which a hospital should provide. However, the characteristics of post-hospital services are extremely different across local communities. The nature of patient needs also vary widely, depending on the characteristics of particular hospitals. The Departments current approach, therefore, is to leave considerable latitude to hospitals in designing discharge planning processes, but to review vigorously the adequacy and appropriateness of discharge planning. This approach seems the best way to assure that the unique features of each community are accomodated in the discharge planning process. Until we have experience with this approach, we think it is inappropriate to tell hospitals how to perform discharge planning.

**Section 202:** Extension of waiver of liability provisions to certain coverage denials for home health services.

We oppose this provision. This provision represents a major policy shift and is inappropriately placed in a quality assurance bill. This provision would extend the waiver of liability to services not covered under the Medicare program and greatly expand the existing home health benefit which is already one of the most rapidly growing benefits covered by Medicare, both in terms of the number of beneficiaries served, the number of patient visits and the increase in expenditures.

**Section 203:** Continuing favorable presumption waiver of liability for skilled nursing facilities and home health agencies

We oppose this provision. Additional legislative authority is unnecessary since the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 extended the waiver of liability for skilled nursing facilities and home health agencies. It is important to note, however, that removing the regulatory favorable presumption would not alter the statutory limitation on liability provision. Providers can continue to show, on a case by case basis, that they did not know or could not reasonably have been expected to know that services were not covered by Medicare.

-4-

**Section 204:** Development of uniform needs assessment instrument

We believe this provision, which would require development of a new uniform needs assessment instrument, is unnecessary. There currently exists a number of assessment instruments in the private and public sectors. We will be happy to brief the Committee and Committee staff about these numerous instruments. We believe the Committee's interest may best be served by examining these rather than asking for the "wheel to be reinvented."

**Section 205:** Expedited review by fiscal intermediaries

We agree that SNFs and HHAs should have access to correct information and believe pre-admission review is the appropriate method for providing this information. The Department plans to pilot test "prior-authorization" for SNFs and HHAs beginning this summer. Data from this pilot test, projected to be available by February 1987, will provide information needed to make an appropriate decision on the feasibility and cost of instituting prior-authorization.

**Section 206:** Prompt response to inquiries concerning exhaustion of Medicare skilled nursing facility benefits

This requirement would not provide the beneficiary safeguard for which it is obviously intended. The information provided, if in fact it were possible to provide it within 24 hours, would only be as accurate as HCFA's latest receipt of billing data. Since exhaustion of benefits is a rare situation, occurring in less than one out of every 500 admissions, this provision would not be cost-effective.

**Section 207:** Provider representation of beneficiaries on appeals and permitting appeal of certain technical denials

HCFA continues to oppose this provision which benefits providers and costs beneficiaries. Our policy prohibits providers or their non-attorney employees from representing beneficiaries in pursuing claims through the Part A appeals process, although a provider may appeal in its own right medical necessity denials and waiver of liability findings. In addition, a provider's and beneficiary's interests may also conflict in cases of overpayment. For example, under section 1870 of the Social Security Act, a beneficiary, rather than a provider, is considered to have been overpaid if the provider can show it was without fault and acted in good faith. Thus, in this case, allowing the provider to represent the beneficiary could result in out of pocket costs to the beneficiary to the provider's benefit. A conflict of interest may also arise in instances where a provider represents a beneficiary in pursuing a claim under section 1879(b). Under this section, a provider is held liable for the payment of expenses incurred by the beneficiary for noncovered items if the provider has billed and received payment from the beneficiary. The Medicare fiscal intermediary will upon request, and receipt of proper documentation from the beneficiary, reimburse the beneficiary and recover payment from the provider.

**Section 208:** Including in annual reports on the prospective payment system information on quality of post-hospital care

Information on reconsideration and appeals is available. We will be glad to include this data in the annual PPS Impact Report.

**Section 301:** PRO review of inpatient hospital services and early readmission cases

We share the Committee's concern with the data problems plaguing the PRO program. This provision would require PROs to collect monthly data directly from hospitals and require PROs to review readmissions within 31 days. The collection of monthly data from the hospitals would require hospitals to complete two PATBILLS instead of one, adding to their administrative burden. We have addressed the issue of readmission resulting from a previous premature discharge through the PRO Scope of Work for the 1986-1988 contract period. We believe that review of readmission within 15 days is sufficient to determine whether a systemic problem exists within a facility. We believe that review for a longer period of time would, therefore, not be cost effective. However, we will be examining in our data analysis whether readmissions after 15 days seem to be affected by changes in reduced lengths of stay brought about by PPS.

**Section 302:** Requiring PRO review of quality of care

PRO review is only two years old. PROs are gaining experience -- as are we in the administration of the program. We believe it would be unnecessary to ove load PROs at this time with additional review responsibilities.

**Section 303:** Requiring consumer representative on peer review boards

The new PRO Scope of Work includes a requirement for the PRO to develop a community outreach program. One of the ways specified for the PRO to fulfill this requirement is to include a beneficiary representative on its board.

**Section 304:** Improving peer review responsiveness to beneficiary complaints

We agree that improving PRO responsiveness to beneficiary complaints is important. PROs are required to investigate all complaints about quality of care received by the Department (or by the PRO). The handling of such complaints is one of the areas in which PRO performance is monitored. PROs are required to comply with HCFA regulations regarding disclosure of information and to submit a confidentiality plan for HCFA's approval. We believe this requirement provides adequate assurance that complaints will be handled in a confidential manner.

**Section 305:** Sharing of information by Peer Review Organizations

We agree that sharing information by PROs is important. PROs are required to disclose confidential information, including medical necessity determinations which show practice or performance patterns of a practitioner. This information is provided, upon request or at the PRO's initiative, to State or Federal licensing bodies. In addition, PROs are required to report serious cases of poor quality to the Inspector General for investigation and appropriate action. Under the current sanction regulations, when the Inspector General takes action, the public and certain specified Federal, State and local agencies are notified. We believe that this is the appropriate time to disclose cases to those groups specified in H.R. 4638.

**Section 401:** Study to Develop a strategy for quality review and assurance.

We agree with the need for research in this area, but do not believe that additional studies are necessary since we currently have 7 major quality studies underway. We expect that these quality studies will provide needed information on the actual impact of PPS on patient health status and how PRO review should be further refined.

Chairman STARK. I appreciate that. As I say, I am sure because of the interests in this both on a bicameral and a bipartisan issue, that we will do something on it, but I also assure you I don't want to proceed hastily, and certainly would not want to proceed without your counsel and participation in any markup procedures. The door is open and we look forward to your continued participation as we try and fashion the final legislation.

Mr. FLEMING. We are in the process of looking at the provisions of the bill, and would expect to be able to submit answers for the record to your questions within 7 to 10 days, Mr. Chairman.

Chairman STARK. Thank you very much.

Let me ask you a couple of questions, if I may, that will at least give you some indications of the kinds of things we are concerned with. Do you have any feeling or have you debated whether the funding for the peer review organizations is adequate for monitoring quality at this point?

Mr. FLEMING. Up to this point we are satisfied, given the scope of PRO review, that we have adequate funds.

Chairman STARK. What do you hear from the PRO's? Do they agree with that?

Mr. FLEMING. I think the PRO's would probably like to have more funds.

Chairman STARK. Can you quantify that at all?

Mr. FLEMING. No, I really can't.

Chairman STARK. Are you 10 percent apart?

Mr. NATHANSON. Let me just make a comment. We have had a series of audits conducted by the audit agency of our Department of the adequacy of PRO funding. They have concluded that on the whole the PRO's were funded adequately during the first contract period. We are now going into the second contract period.

There has been an increase in the funding, as you are aware, and we are negotiating contracts that we believe are comfortable, in the same way that the first round contracts were comfortable for the PRO's. As Mr. Fleming indicated, of course the PRO's would like to have more money. That is to be expected.

Chairman STARK. Does ProPAC get into this issue in terms of funding the PRO's?

Mr. NATHANSON. I think they are going to testify. Perhaps you can ask them.

Chairman STARK. If they don't, would you have any objection to their doing that?

Mr. FLEMING. I think we are always——

Chairman STARK. You don't have to agree with the recommendations.

Mr. FLEMING. We are always interested in what they have to say. Certainly we would entertain any comments they might have.

Chairman STARK. There will be other questions we will submit for your written answers. We understand you may want to take some time on that. We appreciate your indicating that you are willing to participate in this exercise, and hope that we can work together so that we can have your support for whatever legislation may come out.

Mr. FLEMING. That is our interest also, Mr. Chairman.

Chairman STARK. Thank you very much.

[Questions and answers follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
Washington, D.C. 20201

AUG 6 1986

Mr. Fortney H. (Pete) Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20015

Dear Mr. Stark:

I appreciated the opportunity to appear before your Subcommittee at the April 23rd hearing on the Medicare Quality Protection Act of 1986. Enclosed are responses to questions you requested for the record subsequent to that hearing. Although we have submitted our comments to you on the Medicare Quality Protection Act of 1986, I have attached a copy for your convenience.

Sincerely yours,

Bartlett S. Fleming
Associate Administrator for
Management and Support Services

Enclosure

**Questions submitted by Chairman Stark subsequent to the April 23, 1986 hearing on the Medicare Quality Protection Act of 1986**

1. Q. In a study conducted for the Health Care Financing Administration (HCFA), Dr. Janet Mitchell reported that the Diagnosis Related Groups (DRGs) only explained between 16 to 30 percent of the variation in hospital costs on a per-case basis. Other data also suggest that many DRGs are very heterogeneous from the standpoint of hospital costs.

   (a) Does the apparent heterogeneity of the DRGs mean that allowed payments may vary substantially from actual costs in individual cases?

   (b) Could this create incentives to provide less care than needed?

   A. Dr. Mitchell's study focused on hospital-level cost per case and not on individual cases. She did not include a number of adjustments which HCFA makes in paying hospitals, which result in a payment system which accounts for about 60 percent of variation among hospitals. Nevertheless, costs can differ significantly from payments for individual cases, especially in heterogeneous DRGs. We do not believe that these differences for individual cases place a hospital under pressure to provide less care than individual case needs because the cases with costs higher than payments tend to average out with other cases whose costs are lower than payments. Thus, the hospital receives a sufficient total payment to provide needed care for all its Medicare beneficiaries.

2. Q. The current ICD-9-CM DRGs were primarily based on an analysis of 1979 patient records. Could changes in medical care since 1979 have an impact on the economic homogeneity of the DRGs?

A. Yes, changes in medical practice patterns and the adoption of emerging technological advances have altered the resource consumption associated with the treatment of several diagnoses since 1979.

For example, in 1979, treatment of patients experiencing severe coronary artery obstruction required open chest surgery to relieve the obstruction. Currently, the treatment of choice for most such patients is percutaneous transluminal coronary angioplasty (PTCA). This new technology is much safer for patients, necessitates significantly fewer inpatient days, and requires far fewer hospital resources. On average, the widespread adoption of this new treatment practice has cut in half the cost of successfully treating patients with coronary artery obstructions.

The law requires that the Secretary recalibrate the DRGs at least once every 4 years beginning in FY 86. Recalibration involves the reweighting of the DRG weighting factors, based on more recent Medicare billing data. To the extent that new technology is being used in providing services to Medicare beneficiaries, the billing data will reflect charges for this new technology and, therefore, the new recalibrated DRG weighting factors will reflect the relative resources used in employing this new technology.

The law also requires the Prospective Payment Assessment Commission to take a number of factors into account when determining its recommendations to the Secretary for the annual update to the prospective payment rates. The Secretary is required to take PROPAC's recommendation into account in determining and promulgating each years prospective payment system (PPS) update factor. This is another way in which the impact of new technology is taken into account in the PPS system.

3. Q. Please describe HCFA's current research effort to develop a patient classification system that more fully explains variations in per-case data.

(a) How much money has been budgeted for these efforts in FY 87?

(b) How much is paid out by Medicare under the DRGs.

A. HCFA's research effort to develop a patient classification system that more fully explains variations in per case costs has three important parts.

First, HCFA has been examining the outlier payment system. Data on outliers occurring during the first year of PPS are just becoming available and they suggest that refinements in outlier payments may be a powerful way to improve the accuracy of the payment system. Work in this area will proceed in HCFA-sponsored research centers at Brandeis University and at Rand/UCLA. HCFA will also pursue concurrent internal studies.

Second, HCFA is examining refinements to the DRG system which can be accomplished with existing data. This includes a cooperative agreement with Systemetrics to use disease staging to refine DRGs and a study by Health Economics Research using patient management categories to refine DRGs. Concurrent intramural work has examined specific restructuring of DRGs; such work has resulted in reconfiguring DRGs for alcohol and drug abuse, a new DRG for multiple major joint procedures, and a number of other refinements which are awaiting public comment. Promising intramural work in this area is also proceeding in the National Center for Health Services Research.

Third, HCFA is studying refinements which would require new data collection. These refinements are generally referred to as "severity" adjustments and include the Hopkins Severity Indices, the MEDISGRPS system, and the Apache system. HCFA is sponsoring research in this area at Boston University, Health Data Institute, and Tulane University and is aware of independent research at the University of Michigan. None of these studies will provide enough information to allow HCFA to recommend any severity measurement system for prompt adoption. Such research would be complex, expensive and would take at least 2 years from the date of authorization.

Under the Administration's FY 1987 proposed HCFA research budget of $18.5 million, we expect to fund about $500,000 in ongoing studies of severity of illness and DRG refinement.

Medicare paid approximately $37 billion under the prospective payment system in 1985. Of this amount, approximately $31 billion was reimbursement for DRGs. The remaining $6 billion includes payment for outliers, pass-through items (capital, direct medical education, bad debts for deductible and coinsurance for Medicare beneficiaries, kidney acquisition and nurse anesthesist), indirect medical education and retroactive adjustment payments.

4. Q. What schedule would HCFA recommend for completion of the study contained in sec. 101 of H.R. 4638 to improve the patient classification system used under prospective payment?

A. HCFA does not believe that the requirement of sec. 101 of H.R. 4638 is realistic because the information necessary to frame the required legislative proposal cannot be collected and evaluated in the time period suggested.

Building better measures of severity requires information that is not systematically captured in most hospitals and currently does not exist in national data sets. We are actively pursuing several avenues to fill this information gap and have funded significant amounts of research in this area. However, the research community is far from consensus about what variables, in what combination, represent patient differences which should be recognized in a payment system.

The necessary studies to design severity adjustments for the prospective payment system would take at least 2 years from initiation and implementation would take at least another year. Such studies would provide data for design and implementation of a severity system, but could not compare all alternative systems and would allow initial implementation for only a limited number of high-volume DRGs.

5. Q. How frequently are beneficiaries who receive notices of continued stay denial from hospitals appealing these notices to a peer review organization (PRO)?

A. Hospitals reimbursed under PPS may issue a denial notice to a Medicare patient during a stay if the hospital determines that the beneficiary no longer requires inpatient hospital care and:

- The attending physician concurs with the hospital's decision in writing; or
- The PRO reviews the necessity for continued inpatient care and concurs with the hospital's decision.

After receipt of either the attending physician's or the PRO's concurrence, the hospital must notify the beneficiary in writing that:

- He/she will be liable for the hospital's customary charges for continued stay beginning with the third day after receipt of the notice.

- He/she may request PRO review of the hospital's notice, and the PRO will then review and notify the beneficiary of its determination within 3 working days. (If the PRO requires medical records from the hospital, the PRO must make its determination within 3 working days of receipt of the record.)

- This formal determination is subject to a reconsideration at the request of the patient, hospital or attending physician.

We have made no distinction in reporting between beneficiary and hospital-initiated requests for PRO review of hospital notices of noncoverage. Of the total number of hospital notices of noncoverage (46,377) reported since the inception of PRO contracting in July 1984, an audit of the 10 HCFA regional offices disclosed that an estimated 3,000 cases, or 6 percent, were beneficiary initiated.

6. Q. Would PROs be able to decide continued stay appeals within 2 calendar days after receipt of an appeal?

   (a) Would PRO funding have to be increased to enable expedited review? If so, by how much?

   A. In most cases, PROs would not be able to "decide" continued stay appeals of hospital notices of noncoverage within 2 calendar days. This is because the PRO would generally need the patient's medical record in order to overrule the hospital's notice. The hospital would have to furnish that record to the PRO, and the logistics required in doing so would result in the loss of time for the PRO to review the case. We could require that the PRO review the medical record and make a determination within 2 calendar days of receipt of the record.

   Yes, PRO funding would have to be increased to enable review within 2 calendar days rather than the currently required 3 working days. We estimate that the additional cost of PRO's review within 2 calendar days would be approximately $400,000. This figure includes the cost of PRO resources (e.g., nurse reviewers and physician specialists) for work that would have to be performed on weekends and holidays. This estimate assumes that there will be approximately 6,000 beneficiary appeals per year and that one-third of those would have to be handled outside of the regular working week.

7. Q. How many home health visits were denied on the basis of "homebound" or "intermittant care" requirements? How much payment was denied?

   A. We are not able to provide this specific information since we do not gather data on "homebound" or "intermittant care" denials. However, a study of FY 1984 data by our Bureau of Quality Control indicates that if complete data had been available, appropriate coverage decisions would have resulted in payment denials up to $597 million for non-covered care.

   In FY 1984, only 2.7 percent of all home health care was denied by the fiscal intermediaries for a total amount of $51 million - for both medically unnecessary care and technical denials.

8. Q. What is the interval of time between initiation of care by a home health agency (HHA) or skilled nursing facility (SNF) and the first notice by a fiscal intermediary that payment for these services may be denied?

   A. HCFA does not collect data from the time of the initiation of care until a denial notice is sent. We do collect data from the time a patient is discharged until a bill is received by our intermediaries. On average, in the January-March, 1986 quarter, it took SNFs 86.4 days and HHAs 51.7

days to submit a bill after a patient was discharged. The time of receipt until a bill was ready for payment at our intermediaries averaged 23.8 days for SNFs and 28.7 days for HHAs. It is at the end of this timeframe that a SNF or HHA would receive either a check for payment or denial notice. However, denials often require more time because an intermediary may have to request further information in order to develop a claim before making a determination.

9. Q. Please explain the process that is followed by a provider that wishes to determine whether a beneficiary has exhausted the number of SNF benefit days covered by medicare.

(a) How long does it take for a provider to obtain this information from Medicare?

(b) Could delays in obtaining this information result in unnecessary delays in hospital discharge?

A. If a SNF is concerned that a beneficiary has exhausted his benefits, it may make a non-routine request for entitlement information to its intermediary. The intermediary would then query HCFA for entitlement and days available and inform the SNF. This process takes an average of seven days from when the request is received by the intermediary.

The normal process is for the SNF to review its internal records to determine if the beneficiary had a prior stay in the SNF within the benefit period and question the beneficiary to determine if there was a prior SNF stay or days used within the last 60 days. The SNF then prepares and submits a bill based on the information obtained. The intermediary queries HCFA for entitlement and days available information based on the bill received. If the reply from HCFA indicates that benefits are exhausted, the bill is denied and the denial notice is sent to the beneficiary and provider. As indicated in the previous question, it takes an average of 23.8 days for an intermediary to process a SNF bill using data from the January-March, 1986 quarter. However, denials often require more time because an intermediary may have to request further information to develop a claim before making a determination.

In response to your last question, there is no delay in hospital discharge because of delays in receiving entitlement information. As explained previously, a SNF admission begins before the process is initiated. Exhaustion of benefits rarely occurs, happening in less than one out of every 360 admissions.

10. Q. Please explain HCFA's view that providers should not be allowed to bring appeals on behalf of beneficiaries because of possible conflicts of interest.

a. Please give a realistic example of this concern.

b. Given the complexity of Medicare coverage and payment regulations, is it realistic to suppose that individual beneficiaries would challenge denials of payments?

c. Does the waiver of liability for beneficiaries reduce the incentive for beneficiaries to appeal payment denials?

A. a. HCFA's view on this issue is based on our responsibility to protect the Medicare beneficiary. A provider's interests and the beneficiary's interests do not necessarily coincide. One example of such a conflict of interest is where a provider has been overpaid. Under Section 1870(b)(1) of the Act, a provider is not required to refund an overpayment it received if it was without fault with respect to the payment. In that case liability shifts to the

beneficiary. Thus, an overpaid provider has an incentive to attempt to establish that the payment was correct, i.e., that it was not at fault with respect to the overpayment. If the provider does not prevail in its argument that the payment was correct, but does convince the Administrative Law Judge or Appeals Council that it was without fault, the beneficiary will be liable for the overpayment rather than the provider. Thus the interests of the provider and beneficiary are divergent when a beneficiary is appealing a decision that a provider has been overpaid.

b. In January 1984, HCFA issued instructions prohibiting a provider or its non-attorney employees from representing a beneficiary in a Part A appeal. Notwithstanding these instructions, program statistics show that beneficiaries are filing appeals. In calendar year 1984, 15,379 reconsiderations were initiated by beneficiaries.

Although a provider is barred from representing the beneficiary, it may suggest to the beneficiary names of suitable representatives or otherwise assist the beneficiary in the filing of the appeal.

c. A conflict of interest also arises where Medicare has denied payment for medically unnecessary services or custodial care under section 1879 of the Act (waiver of liability provision) because the intermediary determined that both the provider and the beneficiary knew or should have known that the services were not covered. In this case, the provider has the right to bill the beneficiary for the services. The beneficiary has the right to appeal the decision that the services were not covered as well as the decision that he or she knew or should have known that the services were not covered. In this instance, the beneficiary would in effect be claiming that not only are the services covered but, even if they are not, he had reason to believe they were covered.

If the reviewing authority upholds the determination that the services are not covered but reverses the determination that the beneficiary should have known that they were not covered, the intermediary will indemnify the beneficiary for any amount he paid the provider for the services and will collect that amount from the provider as an overpayment. The provider will in effect not be able to collect from the beneficiary for the services.

In this situation it is in the beneficiary's interest to establish that he did not know and could not have known that the services are noncovered. Is in the provider's interest to establish the opposite, thereby shifting the liability for services furnished to the beneficiary.

11. Q. Please describe HCFA's current efforts to develop a long-term strategy for quality review and assurance activities under Medicare.

A. HCFA, within its Office of Research and Demonstrations (ORD) is currently implementing a comprehensive program of studies to evaluate access and quality of care under PPS. There are seven major studies underway. These studies focus on:

- Examining changes in the process or outcomes of care with the implementation of PPS;
- Finding improved measures of monitoring hospital care;
- Examining health status at the time of discharge; and
- Analyzing the appropriateness of post-discharge care.

Two of the studies involve providing short-term results, covering the effects of PPS on a broad range of hospital utilization and patient care outcomes indicators through pre/post PPS comparisons. Among the indicators being studied are: length of stay, population-based mortality rates, use of intensive care units and others. Reports from studies will be incorporated into the current PPS Impact Report to Congress, and will be available over the long term on an annual basis.

A similar, more intense study is being performed by the Urban Institute for the end-stage renal disease population.

Two, more clinically oriented, detailed studies are being performed through cooperative agreements with the Rand Corporation. The first of these involves a pre/post PPS analysis of the effects of PPS on clinical treatment patterns for selected diagnoses, based upon a thorough examination of the medical records. The second Rand study concerns identifying administrative data useful in discovering quality of care problems in individual hospitals, e.g., diagnosis-specific readmission and mortality rates. Results of these studies will be available within the next 2-3 years.

A pilot study has recently been completed by the Northwest Oregon Health Systems to develop a method for measuring health status at the time of hospital discharge and to measure changes in discharge health status associated with PPS implementation. The results of this study are expected to prove useful in assessing functional ability and the need for post-discharge services, as described below.

With respect to post-discharge services, HCFA (ORD) is undertaking a joint effort with the Office of the Assistant Secretary for Planning and Evaluation (ASPE) which will address Medicare patients' need and access to post-acute aftercare services. The basic approach of this study will involve developing a reliable method of (a) assessing Medicare patients' health status and needs for post-discharge services at the time of discharge, and (b) surveying the adequacy of post-discharge care in relation to patients' health care needs. As part of the post-discharge survey, patient and family burden (including financial burden) will also be assessed. A pilot study to test these methods is currently being designed and is expected to be completed by May, 1987. Following the pilot study a long-term national assessment is planned.

Chairman STARK. Now that we have brought up the good name of ProPAC, the Prospective Payment Assessment Commission, we will ask Dr. Donald Young, who is the Executive Director, to please proceed.

## STATEMENT OF DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Dr. YOUNG. Thank you, Mr. Chairman. I appreciate this opportunity to testify before you and describe ProPAC's activities and concerns which relate to the quality of care received by Medicare patients. The commission shares your concerns regarding the impact of the Medicare prospective payment system on quality of care. In our February report to the Congress, "Medicare and the American Health Care System," we noted several consequences of PPS with a major relationship to quality of care. Specifically, for example, the length of hospital stay has decreased resulting in a need for greater attention to posthospital services. The drop in length of stay occurred because of a reduced number of days in routine care.

Stays in intensive care and coronary care units changed only slightly since the implementation of PPS hospitals; however, hospitals do not appear to have substantially reduced the provision of ancillary services. While services such as radiology and laboratory have declined slightly, some ancillaries such as drugs and supplies have risen. Although patients may be discharged at an earlier point in their recovery, the implication of this change for health care outcomes is uncertain.

Earlier discharge under PPS could represent a decline in the provision of nonacute services to inpatients, but this is not necessarily a reduction in quality, if appropriate services are available in alternative settings. The decline in average length of stay increases demand for postdischarge services. In some areas, however, needed services may not be available. The problems related to earlier discharge may therefore be more related to the absence of postdischarge services than to flaws in the Medicare prospective payments system.

Last year we initiated a specific program of careful review, monitoring and research into a broad set of PPS quality issues. This work led to several recommendations in our April 1, 1986, report to the Secretary of Health and Human Services, and expansion of our work in this area.

Before I comment on the bill you have introduced, let me briefly review our past work and our planned future agenda, much of which is directly related to your bill.

Along with many others, the commission became concerned about reports in the media and in testimony before congressional committees that quality of care was being compromised as a result of the implementation of PPS. We decided that our initial work might best be focused on these reported incidents of poor quality care. Thus, through a research contract, we conducted a systematic review of incidents reported in the media and in testimony related to the quality of care problems since the enactment of PPS.

The results of our study are published in the technical appendixes to our recent report and recommendations to the Secretary. Briefly, the study identified several themes running through all of the reported incidents which raise serious policy issues. These issues include: the discharge of beneficiaries more quickly because of shortened length of stay; a series of misconceptions about how the system works and the nature of patients' rights; the lack of availability or accessibility of alternative posthospital care; and the inability of PRO's to identify and monitor quality of care.

The evidence reviewed in the study illustrates the kinds of problems that Medicare beneficiaries have experienced and perceived under PPS. Perceptions are valuable in identifying problems with PPS, but the present evidence is not sufficient to judge under what circumstances or to what extent quality of care has actually suffered under PPS.

Clearly, earlier discharge, for example, does not necessarily equate with poor quality health care. Rather, it may be to the patient's advantage to receive care at home or in an alternative setting, providing adequate care is available and accessible in an alternate setting. The problem, therefore, may be one of the structure and payment for posthospital benefits and the lack of services in some communities. We believe that the information gathered in this study was significant, and it led us to develop four recommendations which were included in our second annual April 1 report to the Secretary.

The four recommendations related to quality of care, which I would like to submit for the record in their entirety, focus in two general areas: First, the need for more and better information about PPS and its functioning for beneficiaries, physicians, and

hospitals; and, second, the need for expanded PRO review under PPS.

[The recommendations referred to follow the prepared statement.]

As I mentioned, our review of reported incidents found enormous misunderstanding about the most basic functioning of PPS. This misunderstanding is clearly not limited to beneficiaries—in fact, it appears that beneficiaries often receive their misinformation from providers, who also do not understand how the system is designed to function. One of the most serious problems relates to the use of the DRG average length of stay as a definition of length of stay—leading to the oft-quoted "Your DRG is up" misconception.

Chairman STARK. Could I interrupt? I read that in your testimony. I can understand a misconception because I am sure the regulations are complicated and they are certainly at times very confusing to me. In your opinion is that pure confusion? I mean, "Your stay is up, because your average stay is 5 days," and is it driven just by people who generally say, "Gee, this is a 5-day procedure and on the 6th day it is all over," or do you think it is really under great pressure just to save money and that is a perception I am sure it is hard for you to quantify?

Dr. YOUNG. Yes. I think it is likely that there are components of both. There is some misunderstanding and some application of that misunderstanding to the potential for gains. Some may also use the average length of stay figure and blame the Medicare program when the hospital or the provider desires to have the patient leave earlier than he or she would otherwise. So I think there is some application of the misperception.

Chairman STARK. Thank you.

Dr. YOUNG. This problem, coupled with a lack of information about beneficiary appeal rights, led the commission to recommend that the Department develop general information to describe PPS and the way it works and to make this information widely available to providers, consumers, and the public at large. A second recommendation suggests that the Department develop a specific notice written for beneficiaries who are hospitalized describing their rights of appeal in cases where they believe they are being improperly discharged. We are pleased that HCFA has recently written and required hospitals to distribute a notice of appeal rights. We understand that the agency is presently developing a general information pamphlet or brochure as we also recommended.

Two additional recommendations which were generated from our review of the study findings involve limited expansion of PRO review activities beyond the hospital walls. These recommendations call for PRO review of the entire episode of illness, including the quality of care, and outcome, related to skilled nursing or home health care. We noted in our discussion of this recommendation that changed financial incentives under PPS and changing patterns of care result in less frequent use of the hospital and more frequent use of skilled nursing facilities, other community facilities, and the patient's home for treatment.

Thus, the quality and level of care available to beneficiaries in these alternative settings directly influence the outcomes of the ill-

nesses or problems for which beneficiaries were hospitalized, and they can directly affect the overall quality of care the beneficiary receives.

We also recommend that PRO's should be required to review and monitor the quality of care and outcome of outpatient surgery for selected patients and procedures. Again, this is an area where changing practice patterns, encouraged by the PPS incentives and HCFA-mandated PRO activities, have led to an increasing number of surgical procedures being performed on an outpatient, ambulatory basis.

While ProPAC supports efforts to encourage performance of procedures in the most appropriate setting, it believes that the impact of this shift on the quality of care furnished Medicare beneficiaries needs to be further examined.

As you know, Mr. Chairman, the commission meets periodically but has not met since the introduction of your bill. Thus, the commission has not formally reviewed the many provisions of H.R. 4638. Certainly, the general thrust of the bill and many of its provisions are in keeping with the priorities and concerns of the commission. We are pleased that members of the subcommittee are seriously reviewing quality of care problems and will be glad to continue to work with you as you refine your work in this area.

A major provision in the bill requires the Secretary to submit a legislative proposal by January 1, 1988, to improve the PPS classification and payment system to account for variations in severity of illness and case complexity which are not accounted for by the current classification and payment system. We are deeply involved in reviewing this subject. We are very supportive of efforts to better define the problems involved in case complexity and develop solutions for correcting these problems.

We believe the timetable you have suggested is reasonable, though we would caution that while improvements will likely be possible by that time, a panacea should not be expected. Our own work in this area during the next year will involve major commitment to a systematic evaluation of the DRG's to assess the extent and underlying reasons for the heterogeneity which results from case complexity and to identify improvements in case mix measurement.

In addition, we will be monitoring and examining research related to alternative case mix measurement systems. We will also continue to study individual DRG's and make appropriate recommendations for refinements which we believe are necessary to adequately reflect case complexity.

As I noted, we have recommended, as the bill requires, a notice to beneficiaries of their hospital discharge rights. I believe that the general idea of PRO review of denial determinations, as well as changes in the schedule for review and timing of beneficiary liability for payment, would be supported by commissioners.

You have also suggested the completion of a study of the adequacy of conditions of hospital participation in the Medicare program, which seems quite appropriate in light of the radically changed nature of reimbursement under PPS and significant other recent changes in health care delivery. The suggested study of payment

for administratively necessary days likewise is an appropriate area for careful review.

As I noted earlier, ProPAC shares the concern evident in the provisions of your bill which deal with access to appropriate posthospital care. The commission has not been involved in reviewing the specific areas of concern related to skilled nursing facilities and home health agencies covered in title II of your bill, so I cannot comment in detail on these provisions.

The commission shares the concerns related to improved PRO review of quality of care. I have already described our formal recommendations in this area, which would result in activities which are similar to several of those contemplated under title III.

Mr. Chairman, thank you for this opportunity to appear before the subcommittee today to describe ProPAC's activities and concerns related to quality of care. In summary, we agree with the intent of the bill to better understand and improve the quality of care for Medicare patients as they move from the hospital setting to the community and home. I look forward to continuing to work with you on this important area, and I will be pleased to answer any questions you or members of the subcommittee may have.

[The statement of Dr. Young follows:]

TESTIMONY

Donald A. Young, M.D.
Executive Director
Prospective Payment Assessment Commission

Mr. Chairman, I am Donald A. Young, M.D., Executive Director of the Prospective Payment Assessment Commission. I appreciate this opportunity to testify before you and describe ProPAC's activities and concerns which relate to the quality of care received by Medicare beneficiaries. The Commission shares your concerns regarding the impact of the Medicare prospective payment system on quality of care. We are especially concerned, as you are, about the quality of care related to the Medicare patient's transition from the acute hospital setting to the community and home.

We are pleased to note your active interest in this important area, as evidenced by your recent introduction of H.R. 4638, the "Medicare Quality Assurance Act of 1986". We support your efforts to study, better understand, and improve policies related to this transitional period in the care of Medicare beneficiaries.

The Commission has always considered the maintenance of high-quality health care our highest priority. This priority has guided all of our reports and recommendations during the 2 years of our active participation in the policy development process surrounding PPS. In our first annual report to the Secretary of Health and Human Services, containing recommendations for updating and maintaining PPS, we noted that "The Commission is keenly aware that the financial incentives of the prospective payment system may lead hospitals to lower their costs of providing services in a variety of ways, some of which may potentially compromise the quality of care provided to Medicare beneficiaries." In fact, many of the incentives and results expected under PPS have been observed in the two years of the system's operation. Thus, in our February report to the Congress on Medicare and the American health care system, we noted several consequences of PPS with a major relationship to quality of care. Specifically, for example, the length of hospital stay has decreased, resulting in a need for greater attention to post-hospital services.

The drop in length of stay occurred because of a reduced number of days in routine care; stays in intensive care and coronary care units changed only slightly since the implementation of PPS. Surgical patients now enter the hospital closer to scheduled surgery and leave sooner following surgery than previously. Hospitals, however, do not appear to have substantially reduced provision of ancillary services. While services such as radiology and laboratory have declined slightly, some ancillaries such as drugs and supplies have risen.

Although patients may be discharged at an earlier point in their recovery, the implications of this change for health care outcomes are uncertain. Earlier discharge under PPS could represent a decline in the provision of nonacute services to

inpatients. But this is not necessarily a reduction in quality, if appropriate services are available in alternative settings.

The decline in average length of stay increases demand for post-discharge services. In some areas, however, unavailability of these services limits access to needed services after dishcarge. The problems related to earlier discharge may, therefore, be more related to the absence of post-discharge services than to flaws in the Medicare PPS.

The Commission strongly perceives its role as supporting the establishment of payment rates that will enable hospitals to continue to deliver high-quality health care. Thus, Commissioners have given implicit and explicit consideration to quality of care during debate and deliberations surrounding recommended changes needed to update payment amounts and appropriately modify the DRG classification and weights. Adjustments to the DRG classification system are also important to encourage the use of more costly, but quality of care-enhancing new technologies and medical practices.

Last year, we also initiated a specific program of careful review, monitoring and research into a broader set of PPS quality issues. This work led to several recommendations in our April 1, 1986 report to the Secretary and expansion of our work in this area. Before I comments on the bill you have introduced, let me briefly review our past work and our planned future agenda which is directly related to your bill.

ProPAC Study of Perceptions of Quality of Care

Along with many others, the Commission became concerned about reports in the media and in testimony before Congressional committees that quality of care was being compromised as a result of the implementation of PPS. We decided that our initial work might best be focused on these reported incidents of poor quality care. Thus, through a research contract, we conducted a systematic review of incidents reported in the media and in testimony related to possible PPS quality of care problems. We undertook this study for several reasons. First, it seemed appropriate to review reported incidents to ascertain if there was a pattern of problems or abuses related to quality. Secondly, even if the incidents reported were unrelated to quality, the perception of quality problems on the part of large numbers of beneficiaries and citizens seemed to us to call for thoughtful review of the situation and corrective action. Finally, we thought that a study of perceived quality of care problems would lead us to enhanced understanding of this area and assist us in further defining our future research and analytic agenda.

A few weeks into the study, we encountered difficulties in identifying incidents of quality problems reported in the media. We then took steps to expand the scope of the study to include review of letters graciously made available to us by the American Association of Retired Persons. These letters were from beneficiaries who had experienced problems they felt related to quality since the beginning of PPS. The study also included interviews with beneficiaries, providers, Peer Review Organizations, and leaders of associations representing these groups.

The results of our study are published in the Technical Appendixes to our recent report and recommendations to the Secretary. Briefly, the study identified several themes running though all of the reported incidents, which raised serious policy issues. These issues include: the discharge of beneficiaries more quickly because of shortened length of stay; a series of misconceptions about how the system works and the nature of patients' rights; the lack of availability or accessibility of alternative post-hospital care; and the inability of PROs to identify and monitor quality of care.

As noted in the conclusions of this study, the evidence reviewed illustrates the kinds of problems that Medicare beneficiaries have experienced under PPS. Perceptions are valuable in identifying problems with PPS, but the evidence present is not sufficient to judge under what circumstances or to what extent quality of care has actually suffered under PPS. Clearly, earlier discharge, for example, does not necessarily equate with poor quality health care. Rather, it may be to the patient's advantage to receive care at home or in an alternative setting, providing adequate care is available and accessible in an alternate setting. The problem, therefore, may be one of the structure and payment for post hospital benefits and the lack of services in some communities. We believe that the information gathered in this study was significant, and it led us to develop four recommendations which were included in our second annual April 1 report to the Secretary.

Recent ProPAC Recommendations Related to Quality of Care

The four recommendations related to quality of care which I would like to submit for the record in their entirety focus in two general areas: first, the need for more and better information about PPS and its functioning for beneficiaries, physicians, and hospitals; and, second, the need for expanded PRO review under PPS.

As I mentioned, our review of reported incidents found enormous misunderstanding about the most basic functioning of PPS. This misunderstanding is clearly not limited to beneficiaries -- in fact, it appears that beneficiaries often receive their

misinformation from providers, who also do not understand how the system is designed to function. One of the most serious problems relates to the use of the DRG average length of stay as a definition of length of stay -- leading to the oft-quoted "Your DRG is up" misconception. This problem, coupled with a lack of information about beneficiary appeal rights, led the Commission to recommend that the Department develop (1) general information to describe PPS and the way it works and to make it widely available to providers, consumers, and the public at large; and (2) a specific notice written for beneficiaries who are hospitalized describing their rights of appeal in cases where they believe they are being improperly discharged. We are pleased that HCFA has recently written and required hospitals to distribute a notice of appeal rights. We understand that the agency is presently developing a general information pamphlet or brochure as we also recommended. We believe that, well into the third year of PPS, these materials are long overdue. We hope that their availability will improve the understanding of the prospective payment system and result in fewer negative perceptions of the system and of the quality of care being delivered.

Two additional recommendations which were generated from our review of the study findings involve limited expansion of PRO review activities beyond the hospital walls. These recommendations call for PRO review of the entire episode of illness, including the quality of care (and outcome) related to skilled nursing or home health care. We noted in our discussion of this recommendation that changed financial incentives under PPS and changing patterns of care result in less frequent use of the hospital and more frequent use of skilled nursing facilities, other community facitilities, and the patient's home for treatment. Thus, the quality and level of care available to beneficiaries in these alternative settings directly influences the outcomes of the illnesses or problems for which beneficiaries were hospitalized, and they can directly affect the overall quality of care the beneficiary receives.

We also recommended that PROs should be required to review and monitor the quality of care and outcome of outpatient surgery for selected patients and procedures. Again, this is an area where changing practice patterns, encouraged by the PPS incentives and HCFA-mandated PRO activities, have led to an increasing number of surgical procedures being performed on an outpatient, ambulatory basis. While ProPAC supports efforts to encourage performance of procedures in the most appropriate setting, it believes that the impact of this shift on the quality of care furnished Medicare beneficiaries needs to be further examined.

We hope that addressing these issues will alleviate some of the more critical short-term perceived and real quality of care problems. We also hope that implementation of these suggested

procedures will lead to more sophisticated review of health outcome related quality measures and focus attention on health system problems related to accessibility and availability of care after the hospital discharge. Our own plans are to increasingly focus our attention on quality studies which relate to the problems of management and provision of post-hospital acute care services and measurement of health outcomes under PPS.

Medicare Quality Assurance Act of 1986

As you know, Mr. Chairman, the Commission meets periodically but has not met since the introduction of your bill. Thus, the Commission has not formally reviewed the many provisions of H.R. 4638. Certainly, the general thrust of the bill and many of its provisions are in keeping with the priorities and concerns of the Commission. We are pleased that members of the Subcommittee are seriously reviewing quality of care problems and will be glad to continue to work with you as you refine your work in this area.

A major provision in the bill requires the Secretary to submit a legislative proposal by January 1, 1988 to improve the PPS classification and payment system to account for variations in severity of illness and case complexity which are not accounted for by the current classification and payment system. We are deeply involved in reviewing this subject. We are very supportive of efforts to better define the problems involved in case complexity and develop solutions for correcting these problems. We believe the timetable you have suggested is reasonable, though we would caution that while improvements will likely be possible by that time, a panacea should not be expected. Our own work in this area during the next year will involve major commitment to a systematic evaluation of the DRGs to assess the extent and underlying reasons for the heterogeneity which results from case complexity and to identify improvements in case mix measurement. In addition, we will be monitoring and examining research related to alternative case measurement systems. We will also continue to study individual DRGs and make appropriate recommendations for refinements which we believe are necessary to adequately reflect case complexity.

As I noted, we have recommended, as the bill requires, a notice to beneficiaries of their hospital discharge rights. I believe that the general idea of PRO review of denial determinations, as well as changes in the schedule for review and timing of beneficiary liability for payment, would be supported by Commissioners. You have also suggested the completion of a study of the adequacy of conditions of hospital participation in the Medicare program, which seems quite appropriate in light of the radically changed nature of reimbursement under PPS and significant other recent changes in health care delivery. The



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suggested study of payment for administratively necessary days likewise is an appropriate area for careful review.

As I noted earlier, ProPAC shares the concern evident in the provisions of your bill which deal with access to appropriate post-hospital care. The Commission has not been involved in reviewing the specific areas of concern related to skilled nursing facilities and home health agencies covered in Title II of your bill, so I cannot comment in detail on these provisions.

The Commission shares the concerns related to improved PRO review of quality of care. I have already described our formal recommendations in this area, which would result in activities which are similar to several of those contemplated under Title III.

Mr. Chairman, thank you for this opportunity to appear before the subcommittee today to describe ProPAC's activities and concerns related to quality of care. In summary, we agree with the intent of the bill to better understand and improve the quality of care for Medicare patients as they move from the hospital setting to the community and home. I look forward to continuing to work with you on this important area, and I will be pleased to answer any questions you or members of the subcommittee may have.

RECOMMENDATION 15: BENEFICIARY AND PROVIDER INFORMATION

**The Secretary should take immediate action to provide more and better-written information about the Medicare prospective payment system to beneficiaries and providers of care. The Department should work with providers, beneficiaries, and associations of these groups to produce and disseminate this information. Associations of providers and beneficiaries should also increase their own efforts to better educate and inform their members about the Medicare prospective payment system.**

Negative perceptions of the quality of care received under the prospective payment system are widely held and have received increasing attention. Some of these negative perceptions may not reflect the actual quality of the care received; rather, they may flow from misperceptions about PPS communicated to the beneficiary. The Commission particularly takes note of reported instances in which the average lengths of stay for the DRGs, as published in PPS regulations, have been used either implicitly or explicitly to limit a patient's hospital stay. The instances, for example, include patients being told it is time for them to leave because "their DRGs have run out." In addition, some hospital notices of noncoverage are apparently predicated on a notion that a patient's DRG length of stay limit has been reached. The Commission emphasizes that published lengths of stay for each DRG should be regarded as averages. It is inappropriate to apply them as absolute limits.

The Commission urges considerably greater educational efforts to inform beneficiaries about the PPS. Although the payment system began in most hospitals during late 1983 and early 1984, it was not until the spring of 1985 that HCFA made available any general purpose information aimed at beneficiaries explaining some of the common misperceptions about the system. It was not until February 1986 that HCFA mandated that hospitals inform patients of their appeal rights with respect to discharge decisions. Even today, there is no general PPS fact sheet or information available nationally from HCFA, for either beneficiaries or providers, including physicians.

These groups badly need such information -- particularly hospitals and physicians -- because they are often called upon to explain the system to the beneficiaries, who have no other available information source. The Commission applauds HCFA's plans to develop such information for beneficiaries. It is not aware, however, of any plans for similar efforts to educate either hospital personnel or physicians. HCFA should make every effort to ensure that materials are widely available to both providers and beneficiaries.

In addition to an increased effort within HCFA and other appropriate HHS organizations, ProPAC also encourages other provider and beneficiary organizations to assist in this important but complex educational effort. The Commission commends efforts by groups such as the American Association of Retired Persons for the materials that they have already developed. It encourages other organizations to develop and disseminate educational materials to their members, patients, and the general public.

**RECOMMENDATION 16: NOTICE TO BENEFICIARIES OF RIGHTS**

**Beneficiaries should be made aware of the process of reconsideration and appeal of a hospital denial of coverage for continued inpatient hospital care. Notification should be through a written notice or information bulletin. It should explain beneficiary rights in a clear, helpful, and understandable manner. In addition to a clear statement of rights, the bulletin should inform beneficiaries that they should not accept any oral communication to the effect that they must leave the hospital because their "coverage" has "run out" or because there is a limit on the number of days "allowed" by Medicare for a DRG. The bulletin should be distributed at the time of admission or as soon thereafter as it appropriate based on the patient's clinical condition. However, additional avenues of distribution should also be developed.**

HCFA provides, by regulation, that beneficiary coverage for continued inpatient care may be denied if a hospital determines that the beneficiary no longer requires this care. The beneficiary may appeal this denial. The hospital is not required to give such notice to a beneficiary routinely, but only when it intends to charge the beneficiary for continued stay. The PROs are responsible for monitoring the denial notices to see that they are correct and do not mislead the beneficiary or misstate the authority or responsibility of the hospital in issuing the notice.

In February 1986, HHS announced the development of a one-page summary of information describing the patient's rights. The hospital is to give this bulletin, entitled "An Important Message from Medicare" to each Medicare beneficiary upon admission. HHS developed the bulletin after careful consultation with a group of organizations representing Medicare beneficiaries and national health care provider organizations. The bulletin will fulfill the intent of this recommendation, and ProPAC commends the Secretary for the action that has been taken.

The Commission regards this bulletin as a critical first step in providing information to beneficiaries. Because it has not yet been distributed to hospitals, and its usefulness to beneficiaries is not yet known, the Commission has chosen to submit this formal recommendation. ProPAC will continue to monitor the use and usefulness of this bulletin.

Further, the Commission maintains that the Secretary should not limit distribution of the bulletin to the time of beneficiary admission. The Secretary should make every effort to distribute it at other appropriate times. Copies could be made available at offices of the Social Security Administration, for example, and in various Medicare program and Social Security Administration mailings to beneficiaries. They could also be distributed through the auspices of associations and other groups involved in health care for the elderly.

RECOMMENDATION 17: PRO EPISODE OF CARE REVIEW

**The focus of PRO quality of care review should be, to the extent possible, on the entire episode of care. The PRO's review should include, in addition to the period of hospitalization, the quality of care (and outcome) related to the overall episode of illness, including, if appropriate, skilled nursing or home health care.**

A primary determinant of the quality of care administered to a hosptial inpatient is the outcome of the episode of care. Changed financial incentives under PPS, and changing patterns of care, are resulting in less frequent use of the hospital and more frequent use of skilled nursing facilities, other community facilities, and the patient's home for treatmnet.

The quality and level of care available to beneficiaries in these alternative setings directly influence, therefore, the outcomes of the illnesses or problems for which beneficiaries were originally hospitalized. They can directly affect the overall quality of care beneficiaries receive. The problem of premature discharge, for example, may not be insufficient hospital services, but rather inadequate clinical management of the postacute patient.

The focus of PRO review should, therefore, be on quality of care and patient outcomes as measured over the entire spectrum of services provided -- institutional and ambulatory. Quality-of-care monitoring during the course of inpatient care should be strengthened. Medical status at the time of discharge should be determined to deter and prevent premature discharges, and the availability of alternative services in the community should be determined. In addition, outcome measures such as follow-up data on patient survival and functional status should be established and applied. A pilot program of long-term review, based on an appropriate sample of beneficiaries and including outcome measures, should be instituted.

RECOMMENDATION 18: PRO REVIEW OF OUTPATIENT SURGERY

**The Commission is concerned that efforts to shift surgical services from the inpatient to the outpatient setting could have an adverse impact on quality of care for certain Medicare beneficiaries. The PROs should be required to review and monitor the quality of care (and outcome) of outpatient surgery for selected patients and procedures. As a starting point, the PROs should be required to review outpatient surgery cases for those procedures that have been identified for preadmission review, including in particular a sample of those cases for which the PRO has denied payment on preadmission review.**

An increasing number of surgical procedures that previously were performed on an inpatient basis are now being performed in ambulatory settings. The movement of surgical services from the inpatient to the outpatient settings has been further encouraged by HCFA policies requiring PROs to reduce admissions for procedures that could be performed in an ambulatory surgical setting. This has been accomplished through various review mechanisms, including preadmission review, random sampling for short stays, and the establishment of admission reduction objectives.

The Commission supports efforts to encourage performance of procedures in the most appropriate setting. It believes, however, that the impact of this shift on the quality of care furnished Medicare beneficiaries must be examined.

The Commission is aware that review of outpatient surgical cases is a significant expansion of the PROs' responsibilities. The PROs, however, are already required to perform preadmission review and to deny payment for procedures that could appropriately be furnished on an outpatient basis. The Commission believes that it is a reasonable next step to require the PROs to review the quality of outpatient care where payment for inpatient care has been denied. Furhter, since both HCFA and the PROs have developed criteria regarding procedures they deem appropriate for ambulatory settings, the cases undergoing outpatint surgery procedures established by these criteria should also be reviewed. In addition, categories of patients who may be at high risk because of outpatient surgery, such as the frail elderly, deserve special concern.

Chairman STARK. Would you like to inquire?

Mr. RANGEL. Thank you, Mr. Chairman.

Chairman STARK. Without objection, Mr. Rangel has another committee meeting.

Mr. RANGEL. The Select Narcotics Committee, which I chair, is having a press conference at 11 o'clock and I am going to have to leave, but I would like to ask a few questions and turn the chair back to one of the most outstanding members of the Ways and Means Committee, who can make a contribution even in the absence of the chairman of the subcommittee.

Mr. DAUB. Repeat that.

Mr. RANGEL. Dr. Young, I know that by January 1988 the Medicare Quality Protective Act requires the Secretary to submit to the Congress recommendations to improve the patient classification system, and that to me seems like it is a long way off, especially with all of the concern that the Congress and the citizens have as to whether or not this system is really working. Do you consider 1988 early enough to get back to us on the report?

Dr. YOUNG. I think that it is a reasonable date for a report that would deal with a major restructuring of the system. In the meantime, however, with the first year's regulations published by the Secretary after our first report, this year incremental changes are being made. We have examined a number of DRG's that we believe can be and should be restructured to better promote equity of payment and foster quality of care delivery. So there is still activity underway both by the Department and by ProPAC in its recommendations to the Department to continue to make the improvements, now and in the months and years before January 1988.

We do not feel, however, that these incremental improvements are going to deal entirely with all the problems that have been raised; for example, by restructuring the DRG or adding better measures of case complexity, you will still be confronted with this problem of post-acute care services.

Mr. RANGEL. One of the major problems I have in my community sometimes is not really the quality of care that is given in the hospitals but the perception of that care, and as you well know, with all of the better hospitals advertising and then competing, patients really have a concern as to what they should expect.

Under the PPS, as you well know, a lot of people, many of us in the Congress, have a perception that many of the hospitals prematurely discharge the patients, in order to improve their financial fiscal status. What can be done by the Government to give some hope to the patient that this perception is not well founded?

Dr. YOUNG. Well, to an extent, the perception is a perception, but there is a lot of basis in fact for that. The system was designed to provide incentives to encourage hospitals to be more efficient in their services, and one of the major problems may reside not in the prospective payment system nor in flaws in that system, but rather in the absence of services to follow up.

That is, a patient may not need those extra 2 or 3 days for acute care services that are provided at a very expensive level, if those services are available in the community, in the home through home health agencies and other places. So a major problem may not reside with the hospital prospective payment system but rather

with the general structure of post-acute care services which is now very much outdated and is in need of examination and restructuring.

Mr. RANGEL. Mr. Chairman, could I continue, because I don't think I understand your answer. If the executive director in the hospital knows that in any given community that there are no follow-up services available, then that judgment is not basically restrictive as to whether or not the hospital can or should discharge, is it?

Dr. YOUNG. That is right.

Mr. RANGEL. I mean, we are talking about doctors with higher codes of ethics, and I guess the bottom line is that when we find for no reason that a patient has been prematurely discharged, whether because the hospital cannot provide any further service or whether because the hospital knew that the patient could not get the services needed outside of the hospital setting, what provisions do we have to move against that doctor and that hospital for what appears to be criminal negligence?

Dr. YOUNG. Where the services are not available then is a subset of the issue. The mechanism currently is first the PRO review. Is there a medical necessity for the patient to be in the hospital? If there is, then there are mechanisms to deal with that and they would be strengthened through the committee's bill. If in the medical judgment of the attending physician and the PRO review, the patient should be in the hospital, sanctions are one of the other activities needed to be taken against that hospital. I agree.

Mr. RANGEL. Do you think the sanctions are there? You know, I have never heard of any doctors or hospital associations ever becoming upset when we find these horror stories, and I would like to know just how strongly you feel when in fact these things occur.

Dr. YOUNG. My understanding is that initially there was little activity along that line, and that the Department has moved to be more vigorous in application of the sanctions recently. I do not have any data on that.

Mr. RANGEL. You will share that with us?

Dr. YOUNG. I will definitely share that with you, sir.

Mr. RANGEL. Thank you.

Chairman STARK. Mr. Gregg.

Mr. GREGG. Thank you, Mr. Chairman.

How much of this problem of early discharge can be solved by increasing the support facilities available to patients outside the hospitals?

Dr. YOUNG. I think a great deal of it can be. As I mentioned earlier, one of the intentions of the prospective payment system was to reexamine the hospital level of care, which is very costly, and to see if alternatives can be found. The problem resides in changing the payment mechanism and in the absence of making changes in post-acute care services.

We are dealing with an attitude about hospitals and a hospital structure that has evolved in our society throughout the years, with perhaps too much weight being placed on the role of the hospital. Now it is time to examine the benefit structure and the payment for services outside the hospital.

The problem resides, then, in the benefit structure and in the payment policies, but also in the availability of alternative services. There has simply not been time in many cases for those services to be generated.

On the other side of that, however, the amount of hospital services that are being used is diminishing, and the amount of services outside the hospital is increasing. The number of skilled nursing facilities has increased modestly. The need seems to be greater. The number of home health services and the Medicare expenditures for home health services has increased quite dramatically, so those services are being used. But I believe that the need is even greater.

Mr. GREGG. Do you folks have a number to compare what it costs to keep the average patient in the hospital versus the skilled nursing level of care?

Dr. YOUNG. I do not have a specific——

Mr. GREGG. Is it 40 percent less? Can you show it that way?

Dr. YOUNG. I do not have a specific number. There are two parts to the problem. One part is, by and large, it is clearly cheaper to provide the services on the whole in the community, whether in a skilled nursing facility or via a home health agency. The problem that the Department confronts is when you alter the benefits you must also make sure that you develop appropriate administrative controls so that patients who receive the benefits truly need them. There is always the potential that when you expand benefits, you will also expand them to individuals who would not otherwise have had them, and that is the point that the administration makes repeatedly.

So you have to deal both with the unit cost, that is the cost per patient, and then the more aggregate cost, which can become a budget issue.

Mr. GREGG. Do you folks have a proposal in this area? Do you have anything you are moving on in this area?

Dr. YOUNG. We will be examining, as a major research activity of ours next year, this interface with the hospital and postacute care services We will be looking at the process of discharge planning, subacute care, and at criteria that are used for placement, including the availability of services. At this point we are refining our specific plans.

Mr. GREGG. Under this bill as proposed, I believe it calls for a discharge plan to be developed for the patient. Should an element of that plan be an estimate of cost savings in comparison with keeping that patient in the hospital?

Dr. YOUNG. I think that is a very interesting idea. It is an important subject, because as you change from the hospital to alternative services, the beneficiary is also subject to increasing copayment and payment liability. Some understanding on the beneficiary's part of what costs would be involved is a very interesting idea.

Mr. GREGG. I may be wrong, but I sense that what is driving this whole process is the desire to spend less, or at least to not have Medicare spend as much. If you were to give somebody a plan as to what it would cost to leave the hospital versus stay in the hospital, it would seem to me that cost is the issue. That would make sense.

Dr. YOUNG. I think the plan would be valuable not only to the beneficiary but to the other providers. As you are probably aware,

physicians and nurses, individuals involved in the care of the patient traditionally have not had a good understanding of what it costs when they order or provide a service, and there is also a lot of room for better understanding by doctors and other health care providers of the implications of some decisions they make. And your idea for a plan that would have some cost in it would serve a very valuable function there as well.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Daub.

Mr. DAUB. Thank you, Mr. Chairman.

First, I am pleased to join with you in cosponsoring what I think is a piece of legislation that has a lot of potential for good. I want to leave my tongue in my cheek with respect to one item, and that is, of course, to remind the chairman now, and perhaps hopefully I won't have to remind him again in 1977–78 that we asked HHS for lots of studies, and when we don't get them we turn around and use the argument the other way.

Chairman STARK. You mean 1987.

Mr. DAUB. I do think the legislation asks for a lot of things we need to ask for. It is appropriate to begin by asking for studies, but just as a matter of note, asking for a lot of studies sometimes gets us in as much trouble as we are in without them.

I think it is also important to say, Mr. Chairman, that by raising the conscience level of the professionals in the health area, which I think this piece of legislation will do, we will be able to see an even better job being done. I think that hospitals are doing a good job, and professionals are doing a better and better job with discharge planning.

It is an important subject for me, but I do want to give credit to the professions in the industry because I think there is a lot of that going on and I think it is in response to the fact that DRG's, while working, have imperfections and that the perception, as our colleague Mr. Rangel noted, is probably fueled by some doctor somewhere who is saying, "I have got to get you off here, because my days are running out," this is not really the right thing to be saying, taken out of context quite often, but as a matter of fact it is one of the ingredients in the planning of how you manage the costs in the hospital.

It becomes one of the excuses, then, when the horror stories come along, so I think this is an appropriate bill. It is right at this point in time, and it is going to be constructive in its impact, and I hope that we can move it to the full committee, and you will certainly have my support in that regard. We can use it as a point of airing a number of the problems which do now exist.

Let me ask you why do you think a doctor answers the question to his patient that way? Why does a doctor say, "I have got to move you along here because I am running out of days"?

Dr. YOUNG. Our study on perceptions indicated that in part it is because doctors and other providers did not understand the system, in fact that they had significant misunderstanding and lack of information regarding it. Another part is that it is certainly easier, if you can, to point the blame somewhere else. And a general way to do it, if you can, is to point your finger to the Federal Government or to a faceless bureaucrat, so that you could simplify and say,

"Well, your days are up, Medicare says it," and then blame the Government and not have the blame on your shoulders. I think those are some of the reasons that it is done.

Mr. DAUB. I was particularly interested in Mr. Gregg's point with respect to the bottom line being a matter of cost. The thing that I am encouraged by, when you try to get from a socialized medicine concept, as one option, to a voucher which may be an option on the right, that somewhere in the middle we decided to try to manage by objective, so we use DRG's.

Now, the debate is shall we apply them to anesthesiologists and pathologists and to other specialties such as surgery? Should we have a DRG for nursing home care, and can we get out of this mode now of encouraging with Federal money the highest and most expensive, intensive forms of care?

Can we now see the constructive impact of DRG's on developing intermediate levels of care in the less expensive, less intensive settings we have been talking about for years? Will not private industry respond and build another level of care out there that is more affordable, more humane, and less expensive than we have had before? You are going to find that out in this study, aren't you?

Dr. YOUNG. That is part of what we are looking at.

Mr. DAUB. Thank you, Mr. Chairman.

Chairman STARK. Dr. Young, does ProPAC, as part of its charge, review the adequacy of our funding of PRO's?

Dr. YOUNG. No, sir; we have not looked at that issue.

Chairman STARK. Is there any group that would be better able to do that than ProPAC?

Dr. YOUNG. I don't have an answer to that question. We did have two recommendations, as I summarized in my testimony, dealing with expansion of PRO responsibility and PRO review. In developing those recommendations and discussing them with the commission, I think that we implicitly realized that those recommendations would require additional funding. We also felt that the Department's budget and the administrative components of PRO's more appropriately reside with the Department than with ProPAC.

Chairman STARK. Would you as a general theory agree with the proposition that PRO's relative to hospital care and DRG's probably are adequately structured at this point? Whether their funding has gone up to keep track of inflation or not is another issue, but if in fact they expand to cover home health services and skilled nursing facilities, that they may indeed need more resources? Does that make sense to you in the way you see them structured?

Dr. YOUNG. Yes, I think so. As I said, we implicitly assumed that in developing our recommendations, that they expand their areas of responsibility and their areas of authority.

Chairman STARK. Now wander with me through my confusion here for a minute. I don't mean to cast any aspirsions on anyone's morals, motives or integrity, but there are financial incentives, it would seem to me, to people who charge a fee for service or receive salaries or compensation based on their financial compensation, in some cases of a person dealing with a hospital or as part of a hospital staff, for a shorter stay.

I wonder, however, as people need an operation, in my language, is there as much incentive or direct economic ties between, say, the

primary physician, the internist or the family physician, as there would be, a surgeon? Are there different levels of where the incentives just in the normal course of practice would be greater or less?

Dr. YOUNG. That is a very complex question. In the time that I was in practice, I never had the feeling amongst my colleagues that the financial incentives were driving a great deal of what they did. It may have been that their income in the aggregate was sufficient that it wasn't necessary on an individual basis.

If one were to begin to dissect that out, you could argue it and look at it from three perspectives. One is that doctors, like everybody else, get comfortable with a way of behavior. The hospital has been a way of behavior in our society, and you have your schedule, you see your patients, and you develop the capabilities of nurses to do procedures, all in the hospital, and you are very comfortable with that. Any change from that schedule may be uncomfortable.

After you have moved outside the hospital and found that you can do those procedures in your office or in a surgical center, you again may feel a level of comfort. Crosscutting that would be different payment amounts, and in some cases you would make more by having the patient in the hospital—for example, you have the daily visit charge—and in some cases you would make more outside the hospital.

I don't think we could come to general conclusions that one or the other has financial incentives, and my own bias is that at least at the beginning it deals far more with the comfort of the physician in the surroundings and his schedule than it does with any single financial incentive.

Chairman STARK. I have another conception. I don't know what the percentage is, but a lot of people who go into a hospital, say for purely elective procedures, plastic surgery or something like that, even though they may be competent in a legal sense really aren't in a frame of mind to do much shopping. I mean they hurt generally or they are scared.

In my case I would be scared as to my ability to make reasonable, rational decisions. If that is true, and is so for 70, 80, 90 percent, we don't mention this in the bill. We discussed it and, ought there not to be some type of ombudsperson, particularly in the absence of close family, who is not related to the hospital or to the physician, and in a sense sees their job as making sure that this patient at least understands or is selecting what would be sensible alternatives that may or may not be open to him?

I don't know how you might do that. Obviously, a small hospital can't afford an ombudsman or person. PRO's may or may not. Have you had a chance to think about that, or has ProPAC considered those possibilities, and are there any standards by which we might judge the nature of that, a way to economically provide it?

Dr. YOUNG. We have considered it in some selected instances. Traditionally, patients have relied on their physician for this ombudsman's role, and with the belief that they understood the physician's judgment as to the nature of the services they furnished. Where we have dealt with it briefly is in considering one of the incentives of prospective payment—to specialize in services. If hospitals do enough of a particular procedure to do them well, that is a very positive incentive. Communities have done that in areas such

as maternity care on their own without the Government having incentives for a long time.

The down side of that is the more you specialize in certain hospitals, the less services will be available in other hospitals. It clearly has a tradeoff. You gain in the quality and in the efficiency. Research has shown that hospitals that specialize do a better job. On the other hand, you lose in terms of access.

Could an ombudsman help in those decisions or help more than a physician can? I am not at all certain that an ombudsman would add much. It might add more information that would further confuse the beneficiary, and makes his or her value choices even harder to arrive at. I am a little skeptical.

Chairman STARK. What about my other hunch? Is there some relationship between level of income and number of people who have a primary physician and the poor of the community who are more likely to be admitted through the emergency procedure, because they postponed medical care due to income?

I gather there is evidence supporting the theory that in many lower income areas, many people are sicker. And yet they cost us, the system, as much to treat, and in many cases more. Can you think of anything in your studies that might lead you to think that ombudspeople or that type of service might be useful in certain areas or in certain communities?

Dr. YOUNG. Certainly the availability of more information is necessary in many places. Whether a person playing the role of ombudsman or of information broker could play that role I would need to think more about it, but the need for——

Chairman STARK. Could PRO's provide that or would that structurally be beyond their capability?

Dr. YOUNG. I am going to let the PRO people respond to that directly.

Chairman STARK. I appreciate your testimony. We look forward to not only working with your organization as we proceed through this, but I would be remiss if I didn't comment on the high regard with which ProPAC is held I think by this subcommittee and its staff looking forward to working with you as we see what can be done in this legislation. Thank you very much for your testimony this morning, and I am sure the staff would like to submit a couple of other questions to you for the record, and I appreciate your being willing to respond to those in writing.

Dr. YOUNG. Thank you for the opportunity to testify, and for your kind words. We appreciate them.

Chairman STARK. Our next witnesses will consist of a panel, Mr. Eric Shulman, director, office of legislative liaison and research, National Council of Senior Citizens; and Mr. John Denning, president-elect of the American Association of Retired Persons.

**STATEMENT OF ERIC SHULMAN, DIRECTOR, OFFICE OF LEGISLATIVE LIAISON AND RESEARCH, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY JANET MYDER, DEPUTY DIRECTOR, RESEARCH DEPARTMENT**

Mr. SHULMAN. Thank you, Mr. Chairman. I appreciate the opportunity to be here today. I am accompanied by Janet Myder, who is

the deputy director of our research department at the national council. The National Council of Senior Citizens has long advocated prospective payments to health care providers. It is a means to control cost by encouraging efficiency as providers assume financial risks for their actions. However, prospective payment is not an excuse for sacrificing the quality of services rendered. The means to control this undesirable outcome, we believe, is a strong and effective system to monitor and assure quality of care. Such a system is a vital component of PPS.

Mr. Chairman, when congressional hearings on Medicare prospective payment to hospitals were held in 1982 and 1983, the national council presented testimony. We supported with some reservations the proposed DRG plan as a step toward a broader health systemwide cost control policy. We cautioned Congress to consider the DRG plan thoroughly. Our major concern then, as now, was that DRG's potentially would have negative impacts on Medicare beneficiary, in spite of DRG's purported financial benefits to the program.

Certainly we have seen within the last 6 months one of those negative impacts being the dramatic increase in the part A deductible under Medicare as a consequence of reducing lengths of stays and higher costs per day.

Our concerns of 1982 and 1983 have clearly become a reality. The evidence that quality under DRG's has been sacrificed for costs is becoming largely clear and, unfortunately, increasingly abundant as reports become available through informal and formal sources. The congressional testimony, in studies conducted by the GAO, the inspector general of HHS, provider and consumer groups have given us ample evidence that serious problems in quality of care exists and Medicare beneficiaries are indeed being harmed.

No information, however, is more compelling to us than the numerous messages we receive from our members and our families. These tragedies have already been enumerated in countless congressional hearings and in other forums around the country, so I will recount but a few.

Our letters report a man whose wife underwent surgery for a brain tumor in January 1986 had to locate a nursing home for his wife on his own. He wrote, "They"—that is, the hospital—"just gave me a list of nursing homes and told us to call them."

A patient was told to buy and use a walker without any instructions. He later fell down a flight of stairs and was rehospitalized for 3 weeks. The daughter of a 90-year-old man who suffered a stroke was told to get him home from the hospital during a hurricane. After the daughter pleaded with the planner, he was allowed to stay 1 more day. He died at home the day after discharge.

These reports and study results tell us it is time for midcourse corrections. It is time for Congress to use all the information now available on DRG impacts. It is time to enact additional beneficiary protections and to strengthen and enforce quality assurance mechanisms.

For this reason, the NCSC commends you, Mr. Chairman, for recognizing the urgent need to improve quality assurance and end patient abuse under PPS. We support your legislation and the identical bill introduced by Senator Heinz. It is a major step toward solv-

ing the serious problems that hospital care Medicare beneficiaries face today.

We believe that the legislation provides an urgent adjustment to PPS which focuses on the system's human effects largely ignored by an administration which seems more concerned about cost savings than patient abuse. In addition, the plan not only acknowledges that abuse is occurring, it also recognizes that deteriorating quality and patient abuse are taking place in spite of the quality assurance mechanisms currently in effect. H.R. 4638 makes patient rights an essential part of the Medicare beneficiary's legislative protections.

NCSC has been concerned that peer review organizations have been too limited to identify many problems that have been occurring since the DRG program was enacted: For example, the beneficiary who died shortly after hospital discharge, the patient who receives part-time care and more intensive care is needed, the patient who does not receive postdischarge care prescribed, or patients with multiple hospital admissions. The bill's provision to expand PRO's review of hospitals to readmissions within 30 days and to include review of care in posthospital settings are steps toward identifying these problems.

In addition, the provisions to require that hospitals, as a condition of participation in Medicare, have an effective discharge planning process could prevent such problems from arising in the future.

One of the most frequent messages we receive from our members is that they, their families and often their physicians do not know their rights. Too frequently beneficiaries do not know when they have been denied their rights under Medicare, and to make matters worse, when they sense that a problem exists they do not know where to turn for help.

We are pleased that the bill requires hospitals to issue patients a written notice of their rights, that it provides for financial protection against 3 days of continued stay when patient appeals rights, written needs, et cetera. That gives patients the right to appeal notices which do not require patient payment.

We also support expanding patient access to the PRO's to report compliance.

In closing, I emphasize that the effectiveness of the measures I have highlighted as well as the bill's other provisions will be dependent upon many variables: enforcement followup, funding and information related to the bill's specific provisions are just a few. Others are external. For example, deregulation of hospital conditions of participation or inadequate payment may simultaneously compromise quality and undermine the effects of legislation enacted to restore and maintain quality.

Thank you very much, Mr. Chairman.

Chairman STARK. Thank you, Mr. Shulman.

[The statement of Mr. Shulman follows:]

STATEMENT OF ERIC SHULMAN, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, I am Eric Shulman, Director of the Office of Legislative Liaison and Research at the National Council of Senior Citizens. The National Council represents over 4.5 million of the nation's elderly persons through over 4,800 clubs and

State and Area Councils throughout the country. Since the majority of our members are Medicare beneficiaries, we are concerned about the effect of Federal policy on quality of care under the Medicare program. We appreciate the opportunity to comment today on the "Medicare Quality Assurance Act of 1986."

Maintaining quality of care under Medicare has always been a major concern to us as well as to members of Congress. Today, however, the quality of medical care rendered to Medicare beneficiaries is increasingly important and, unfortunately, increasingly at risk. The implementation of Medicare's hospital prospective payment system (PPS) is a major cause of this trend.

The National Council of Senior Citizens has long advocated prospective payment to health care providers. It is a means to control costs by encouraging efficiency as the providers assume financial risk for their actions. However, prospective payment is not an excuse for sacrificing the quality of services rendered. The means to control this undesirable outcome, we believe, is a strong and effective system to monitor and assure quality of care. Such a system is a vital component of PPS.

Mr. Chairman, when Congressional hearings on Medicare prospective payment to hospitals were held in 1982 and 1983, the National Council of Senior Citizens presented testimony. We supported, with some reservations, the proposed Diagnosis Related Groupings' plan as an interim step toward a broader, health system-wide cost-control policy. We cautioned Congress to consider the DRG plan very thoroughly. Our major concern then, as now, was that DRGs potentially would have negative impacts on Medicare beneficiaries in spite of DRG's purported financial benefits to the program.

During those pre-DRG hearings, we expressed concern that the hospitalized Medicare patients would be lost in the shuffle as cost savings gained prominence in Medicare's new payment system. I will now quote two of the most serious concerns that we listed in testimony on February 14, 1983 before this Subcommittee and later before the Senate Finance Health Subcommittee:

"The quality of care administered could be seriously impaired."

"The length of stay could be inappropriately shortened, seriously affecting the Medicare patient's discharge status."

Mr. Chairman, our concerns of 1982 and 1983 have become reality. The evidence that quality under DRGs has been sacrificed for cost savings is becoming alarmingly clear, and, unfortunately, increasingly abundant as reports become available through formal and informal sources. The Congressional testimony and studies conducted by the General Accounting Office, the Inspector General of the Department of Health and Human Services, and provider and consumer groups have given us ample evidence that serious problems in quality of care exist, and Medicare beneficiaries are being harmed. No information, however, is more compelling to us than the messages we receive from our members or their families. Here are some examples:

A woman in North Dakota reported that her 91-year-old husband was hospitalized for two weeks with an infected toe. He was discharged with arrangements made for home care. The woman asked if he could stay in the hospital for the care and was told no, because of "goverment regulations." At home the infection worsened. The man was readmitted to the hospital where he underwent a below-the-knee amputation. After three weeks, hospital personnel informed his wife that they could not collect payment for one week of care and she paid the hospital $1,000.

A man in Mississippi reported that he had surgery for colon cancer on December 24 last year and was discharged on December 31. He was sent home where he lives alone. On January 2, he called an ambulance because he was hemorrhaging. He was readmitted and remained hospitalized for six weeks.

A 72-year-old man in Wisconsin was discharged in spite of intense back pain after a bladder tumor removal. He was readmitted to another hospital one week later and placed in back traction. After six days, his doctor told his wife: "The hospital administrator is on my back. . . . I know he's not ready to go home, but he has to go home." Four days later a CAT Scan, performed at the *same* hospital on an out-patient basis, revealed three cancerous lesions in his spine. He was admitted to another hospital, his third in about four weeks.

A man in Texas wrote to tell us that his wife, who had a history of two hospitalizations in four months for Parkinson's disease and compression fractures of the spine, was hospitalized again for a fractured hip. When it came time for her discharge, he asked why she had to be released. He reports that the doctor told him that under the new law . . . "they had taken the right away from doctors to determine how long a patient needed medical care, and he was not even sure that the hospital would be paid for the full time she was there." Eight days later this woman was readmitted to another hospital.

These are just a few samples. Other letters report: A man whose wife underwent surgery for a brain tumor in January, 1986 had to locate a nursing home for his wife on his own. He wrote, "They (hospital) just gave me a list of nursing homes and told us to call them." A patient was told to "buy and use a walker" without instructions. (He later fell down a flight of stairs and was re-hospitalized for three weeks.) The daughter of a 91-year-old man who suffered a stroke was told to take him home from the hospital during a hurricane; after the daughter pleaded with the discharge planner, he was allowed to stay one more day; he died at home the day after discharge.

These reports and the study results tell us it is time for mid-course corrections. It is time for Congress to use all the information now available on DRG impacts. It is time to enact additional beneficiary protections and to strengthen and enforce quality assurance mechanisms.

The National Council of Senior Citizens commends you, Mr. Chairman, for recognizing the urgent need to improve quality assurance and end patient abuse under PPS. We support your legislation and the identical bill introduced by Senator Heinz. We believe that The Medicare Quality Assurance Act of 1986 (H.R. 4638, S. 2331) is a major step toward solving the serious problems that hospitalized Medicare beneficiaries face today. We believe that the bill could have helped to avoid many of the avoidable situations I have just described.

After we have had the opportunity to thoroughly examine H.R. 4638, we will be pleased to provide you and your staff with our more detailed analysis. Today I will make a general comment and then highlight some of the provisions we believe are essential to maintaining and improving beneficiaries' protection.

We believe that the legislation provides an urgent adjustment to PPS which focuses on the system's *human* effects, largely ignored by an Administration which seems to be more concerned about cost savings than patient abuse. In addition, the plan not only acknowledges that abuse is occurring, it also recognizes that deteriorating quality and patient abuse are taking place—in spite of the quality assurance mechanisms currently in effect. H.R. 4638 makes patients' rights an essential part of Medicare beneficiaries' legislated protections under DRGs.

The National Council of Senior Citizens has been concerned that the Peer Review Organization's focus has been too limited to identify the many problems we have seen occurring since enactment of DRGs, for example, the beneficiary who dies shortly after hospital discharge, the patient who receives part-time home care when more intensive care is needed, the patient who does not receive the post-discharge care prescribed, or patients with multiple hospital admissions. The bill's provisions to expand PRO's review of hospitals to re-admissions within 30 days and to include review of care in post-hospital settings are steps toward identifying these problems. In addition, the provision to require that hospitals, as a condition of participation in Medicare, have an effective discharge planning process could prevent such problems from occurring.

One of the most frequent messages we receive from our members is that they, their families, and often their physicians do not know their rights. Too frequently beneficiaries do not know when they have been denied their rights under Medicare. To make matters worse, when they sense that a problem exists, they do not know where to turn for help. We are pleased that the bill requires hospitals to issue patients, a written notice of their rights, that it provides for financial protection against three days of continued stay when patients appeal written notices, and that it gives patients the right to appeal notices which do not require patient payment. We also support expanding patients' access to the PROs to report complaints.

We believe additional protections are needed for the patients whose discharge notices are verbal only since the appeals process and PRO access would be too limited to help these individuals. The legislation's effectiveness in reducing hospitals' pressure on physicians can help to alleviate some of these problems, but additional measures may be needed.

In closing, I emphasize that the effectiveness of the measures I highlighted, as well as the bill's other provisions, will be dependent upon many variables. Enforcement, follow up, funding, and information related to the bill's specific provisions are just a few. Others are external. For example deregulation of hospital conditions of participation or inadequate payment may simultaneously compromise quality and undermine the effects of legislation enacted to restore and maintain quality.

These are NCSC's preliminary comments on a proposal which promises to restore some of the access to quality of care which beneficiaries have lost since DRGs were enacted. We strongly support this legislation and urge its prompt adoption. We need Congress' vigiliance in safeguarding Medicare beneficiaries' rights. We expect Congressional action to assure the elderly's protection and the program's integrity. We

commend you, Mr. Chairman, for taking these important steps while others are getting swept away in the tide of "cost savings" without regard to the human cost that is clearly evident.

Chairman STARK. Mr. Denning.

**STATEMENT OF JOHN DENNING, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY JACK CHRISTY, SENIOR POLICY ANALYST**

Mr. DENNING. Thank you, Mr. Chairman. My name is John Denning and I am the president-elect of the American Association of Retired Persons. I am accompanied by Jack Christy, senior policy analyst for the association. On behalf of over 22 million members of AARP, I want to thank you for this opportunity to state the association's support for the Medicare Quality Assurance Act of 1986. The association commends you, Mr. Chairman, Senator Heinz, Representatives Gradison, Daub and all of the other cosponsors of this important legislation, for your leadership in addressing the quality of care problems emerging in the Medicare system. Congressman Ed Roybal, chairman of the House Select Committee on Aging, and an original cosponsor of H.R. 4638, should also be commended for his strong leadership in the cause of high quality health care.

The health care system's transition from an environment of seemingly unlimited resources to an environment of stringent cost containment has created issues in the health care system that were taken for granted in the past. Before cost containment, the high quality of American medical care was virtually assumed. Instances of poor quality care were considered to be aberrations in the delivery system. Such cases were appropriately resolved on a case-by-case basis through the courts.

Health care consumers today, however, can take nothing for granted, including the quality of care. This is particularly true for Medicare patients. The financial incentives in the medicare prospective pricing system [PPS] to skimp on care are eroding the Medicare benefit. Medicare patients are leaving the hospital sicker and quicker than ever before. They are being given wrong information by some hospital administrators that their Medicare benefits have run out. Until recently, no information at all about their right to appeal such discharge decision was given.

The development of an adequate quality monitoring and assurance program requires simultaneous action on several fronts, and laws that have to be strengthened in both the acute and postacute care settings. The peer review organization needs greater authority and resources to monitor and enforce quality of care standards.

Access to postacute care services must be made more reliable and predictable. Developing an adequate quality monitor and assurance program will require new research into the outcome of medical care and new data systems to collect appropriate information and make it useful to consumers as well as professionals in the health care sector.

Congressional concern over the quality of Medicare care has generated two important bills, H.R. 4638, the Heinz/Stark Medicare Quality Assurance Act of 1986 [MQAA] and H.R. 4330, the Roybal Medicare Continuing Care Equity and Quality Assurance Act of 1986 [CCEQAA]. Both MQAA and CCEQAA recognize that specific

areas of Medicare program administration must be changed to improve the quality of care under Medicare.

Both bills improve the peer review organizations' ability to monitor the quality of care. The American Association also supports the Heinz-Stark proposal to make discharge planning a condition of participation in Medicare, similarly the Heinz-Stark bill requires DHHS to develop a uniform needs assessment instrument to assist in determining beneficiaries' eligibility for posthospital care. H.R. 4330 builds PRO review of medical necessity and practical considerations into the appeals process for continuing care benefits, allowing PRO's to consider such issues is it important to maintaining a stable continuum of care for frail Medicare patients, living alone or with a frail spouse, by requiring such changes in the current administrative structure of Medicare. The bill improves the reliability and predictability of Medicare posthospital benefits, and therefore improves the quality of care for Medicare patients.

AARP believes consumer involvement is an important factor in the development of the Medicare Program. The association is proud and enthusiastic about the beginning that has been made with consumer representations on boards of directors of 11 PRO's.

Thank you, Mr. Chairman, for your leadership in the cause of maintaining quality care under the Medicare Program. My association's interest in this area is not a selfish interest, an interest just in ourselves. We believe a simple truth binds the generations together in the quest for quality health care. That simple truth is this: The quality of care under Medicare is ultimately indicative of the standard of care for most everyone else in our country, for Medicare is the flagship of the American health care system. Where it leads, others will follow. The issue of concern to Medicare beneficiaries today will be the issue of concern to all health care consumers tomorrow.

Thank you.

[The statement of Mr. Denning follows:]

STATEMENT OF JOHN DENNING, PRESIDENT ELECT, AMERICAN ASSOCIATION OF RETIRED PERSONS

INTRODUCTION

Thank you, Mr. Chairman. My name is John Denning and I am the President-elect of the American Association of Retired Persons. On behalf of the over 22 million members of AARP, I want to thank you for this opportunity to state the Association's support for the Medicare Quality Assurance Act of 1986. The Association commends you Chairman Stark, Senator Heinz, Representatives Gradison, Daub, and all of the other co-sponsors of this important legislation for your leadership in addressing the quality of care problems emerging in the Medicare system. Congressman Ed Roybal, Chairman of the House Select Committee on Aging, and an original co-sponsor of H.R. 4638, should also be commended for his strong leadership in the cause of high quality health care.

My testimony this morning has four sections: (1) Quality of care as the emerging priority; (2) Targeting remedial action; (3) The Heinz/Stark proposals and the Roybal proposals for improving the quality of care; and, (4) other recommendations for maintaining quality in the health care delivery system.

QUALITY OF CARE--THE EMERGING PRIORITY

The health care system's transition from an environment of seemingly unlimited resources to an environment of stringent cost containment has created issues in the health care system that were taken for granted in the past. Before cost containment, the high quality of American medical care was virtually assumed. Instances

of poor quality care were considered to be aberrations in the delivery system. Such cases were appropriately resolved on a case by case basis through the courts.

Health care consumers today, however, can take nothing for granted, including the quality of care. This is particularly true for Medicare patients. The financial incentives in the Medicare prospective pricing system (PPS) to skimp on care are eroding the Medicare benefit. Medicare patients are leaving the hospital sicker and quicker than ever before. They are being given wrong information by some hospital administrators that their "Medicare benefits have run out" and no information at all about their right to appeal such discharge decisions.

The Association recognizes that shorter lengths of stay are not inherently bad or necessarily detrimental to delivering quality health care. But shorter lengths of stay, combined with the Administration's rules tightening access to post-acute care services are creating major deficiencies in the quality of care provided Medicare patients. Medicare patients are too often being discharged from the hospital without an appropriate destination for their recuperation. Medicare patients are falling into "no care zones"—they are no longer receiving an acute level of care and are ineligible or unable to receive the post-acute care services essential to their recovery.

The erosion of Medicare coverage has not gone unnoticed. Committees in both the House and the Senate have held hearings on this issue. Thousands of pages of testimony from patients and their families, doctors, hospital administrators, nurses, discharge planners, and community health care providers document the erosion of Medicare coverage. The General Accounting Office, the Inspector General of DHHS, and the Office of Technology Assessment have also submitted reports to the Congress identifying quality of care problems under the prospective pricing system. AARP too has received hundreds of letters from members, their children and others complaining about the quality of Medicare under PPS.

### TARGETING REMEDIAL ACTION

The development of an adequate quality monitoring and assurance program requires simultaneous action on several fronts. Laws have to be strengthened in both the acute and the post-acute care settings. The peer review organizations (PROs) need greater authority and the resources to monitor and enforce quality of care standards. Access to post-acute care services must be made more reliable and predictable.

Developing an adequate quality monitoring and assurance program will require new research into the outcomes of medical care and new data systems to collect appropriate information and make it useful to consumers as well as professionals in the health care sector.

### H.R. 4638 AND H.R. 4330

Congressional concern over the quality of Medicare care has generated two important bills—H.R. 4638, the Heinz/Stark Medicare Quality Assurance Act of 1986 (MQAA) and H.R. 4330, the Roybal Medicare Continuing Care Equity and Quality Assurance Act of 1986 (CCEQAA).

Both MQAA and CCEQAA recognize that specific areas of Medicare program administration must be changed to improve the quality of care under Medicare. MQAA, for example, calls for the development of a severity of illness index to better differentiate patients within a particular DRG. It also requires hospitals to implement discharge planning as a condition of participation in the Medicare program. CCEQAA, on the other hand, requires HHS to conduct quality assurance activities on all Medicare covered health care providers, including hospitals, physicians offices, nursing homes, home health agencies, and hospices. CCEQAA also requires PROs to maintain a 24 hour hot-line to receive questions and complaints concerning health care quality problems.

Both bills improve the peer review organizations' ability to monitor the quality of care. CCEQAA mandates, for example, that at least one-half of the PROs level of effort must be for the purpose of quality assurance. In addition, CCEQAA builds PRO review of "medical necessity" and "practical considerations" into the appeals process for continuing care benefits. Allowing PROs to consider such issues is important to maintaining a stable continuum of care for frail Medicare patients living alone or with a frail spouse.

The Association strongly endorses the Heinz/Stark proposal to coordinate the number of grace days beneficiaries have when appealing a continued stay denial, with the number of days the PRO has to respond to the appeal. The inherent lack of fairness in the current process for appealing a continued stay denial discourages

beneficiaries from appealing. The coordination of these time periods goes a long way towards making the system more responsive to the patients using it.

The Association also supports MQAA's proposal to make discharge planning a condition of participation in Medicare. It is essential that the post-hospital care needs of Medicare patients be planned for in advance of discharge. CCEQAA would go even further by establishing guidelines and standards for hospital discharge planning to prevent premature discharge and ensure a smooth transition to post-hospital care. Similarly, MQAA requires DHHS to develop a uniform needs assessment instrument to assist in determining beneficiaries eligibility for post-hospital care. By requiring such changes in the current administrative structure of Medicare, the bill improves the reliability and predictability of Medicare's post hospital benefits and thereby improves the quality of care for Medicare patients.

Advance planning for discharge and uniform needs assessment for post-hospital services are essential to the maintenance of quality care under PPS. But the best planning in the world and the best needs assessment in the world cannot protect discharged patients from poor quality care if the necessary post-acute care services are not available. Failure to address the needs of patients requiring post-acute care services, but who are unable to get them, is a major loophole in Medicare's plan for quality care. The Association believes that the concept of "administratively necessary days" (A.N.D.s) must be revitalized to accommodate patients in this situation.

Prior to PPS, patients backed-up in hospitals awaiting placement in a nursing home were permitted to stay in the hospital until a nursing home bed was available. Hospitals serving such patients were paid under the guise of A.N.D.s. HCFAs payments to hospitals for A.N.D.s were incorporated into the DRG rate base. Nevertheless, hospitals have not provided patients with "administratively necessary days" under PPS. Failure to provide A.N.D.s when the DRG rate base includes payment for such care is harming Medicare patients.

Both MQAA and CCEQAA address this loophole by strengthening the procedures for determining patients eligibility for post-acute care services. But such improvements are simply not enough. Quality of care in the Medicare program will remain a problem as long as patients needing care are discharged from hospitals without appropriate post-acute care services.

A similar situation obtains because of the operation of the so-called three day rule. Under current practice, a Medicare patient is not eligible for nursing home care unless the patient was in the hospital for three days prior to discharge to the nursing home. Under PPS entire categories of procedures have been limited to the outpatient setting. Patients recovering from outpatient surgery needing post-acute care services are now not eligible for such services because of the three day rule. The three day rule must be eliminated, or at least modified to accommodate the scores of Medicare outpatients needing post-acute care services.

Both MQAA and CCEQAA require DHHS to study various aspects of the quality assurance system and to report back to Congress. These studies and reports are important because they are the lens through which the American people will view the facts and make decisions about the quality of care in the Medicare system. AARP urges the committee to require DHHS to make the studies and reports called for in these bills. Only through constant questioning of the facts about quality can we develop the kind of quality assurance system that is capable of monitoring and assuring quality care. It is time to develop quality of care data and to organize it so that it is meaningful to consumers as well as providers and payors. The studies and reports called for by these bills are steps in that direction.

Finally, AARP will continue to press for a stronger consumer role in the implementation of the PRO program. A good first step has been taken with the election of AARP supported consumer members to the Executive Boards of eleven PROs. AARP supports the MQAA proposal to require consumer representation on all PRO boards. The consumer/PRO relationship must be extended through board memberships, as well as much more visible PRO efforts to educate the beneficiary community about their rights and responsibilities under PPS.

#### ADDITIONAL RECOMMENDATIONS ON QUALITY OF CARE

I. *The need for data.*—PROs must be funded to support access to and integration of mulitple data bases. The PROs analytic potencial can only be enhanced by increased access to information systems beyond Part A claims data.

Ways of presenting PRO generated data in furtherence of the public interest in better informed consumers must be developed.

II. *Research in quality of care.*—In the past, the commitment to quality health care was assumed by the presence of abundant resources. But skyrocketing health

care costs shifted priorities to cost containment. The resultant DRG system established a new set of financial incentives. Accompanying the incentives to reduce the hospital cost of each inpatient stay is the incentive to undertreat. Grappling with the real and potential quality of care problems under the new system brought to light the need to know more about quality of care. To help focus that light, AARP supports the following research agenda:

Longitudindal studies of patient care must be systematically conducted. Patient health care outcomes must be monitored over time with the focus on such areas as functional status upon admission, changes in patient status as of discharge, the effect of shorter lengths of stay on discharge destination, and the post-discharge experience.

Measurements for quality of care should be studied to develop meaningful outcome measures. Specifically, the relationship of outcomes of medical care to the process of delivering care and the structural characteristics of providers must be examined.

AARP supports legislation that would allocate a fraction of the Medicare Part A Trust Fund for research into medical practice variations. For the past several years, researchers have been tracking variations in the use of medical care and have begun to discover "systematic and persistent" variations in the standardized use rates for common surgical procedures as well as other services. AARP recognizes the need for greater information about clinical outcomes and statistical norms based on average performance.

III. *Strengthening consumer involvement in the Medicare program.*—AARP believes consumer involvement is an important factor in the development of the Medicare program. The Association is proud and enthusiastic about the beginning that has been made with consumer representation on the boards of directors of eleven PROs, as well as the Board of Directors of the American Medical Peer Review Association. But consumer involvement is important in all aspects of the Medicare program, it is the foundation upon which public support is based. AARP believes that consumer involvement in the Medicare program must be statutorily assured by making Medicare subject to the Administrative Procedures Act. Consumers cannot fulfill their responsibility to Medicare if the policies, rules, and regulations governing Medicare can be made in secret and transmitted to Medicare's agent—carriers and fiscal intermediaries—without consumers knowledge and ability to review and comment? Requiring HCFA to publish Medicare rules and regulations for the opportunity to influence the program before decisions about it are implemented. The publication, review and comment requirements of the APA will help keep HCFA from using nonstatutory or nonregulatory rules—such as "technical denials" as a basis for denying Medicare benefits to beneficiaries who need them.

Elliot Richardson, when he was Secretary of Health, Education and Welfare, made a voluntary commitment to subject Medicare to the APA. This Administration has abandoned that commitment. It is time to revitalize that commitment by mandating that Medicare comply with the APA.

CONCLUSION

Thank you again Mr. Chairman for your leadership in the cause of maintaining quality care under the Medicare program. My Association's interest in this area is not a selfish interest, an interest just in ourselves. We believe a simple truth binds the generations together in the quest for quality health care. That simple truth is this: The quality, or lack of it, of care under Medicare is ultimately indicative of the standard of care for most everyone else in our country. For Medicare is the flagship of the American health care system—where it leads others follow. The issues of concern to Medicare beneficiaries today, will be the issues of concern to all health care consumers tomorrow.

Chairman STARK. Thank you very much, Mr. Denning. I would suggest that on this side of the Capitol the bill is known as the Donnelly-Gregg-Stark-Heinz bill. On the other side, you may reverse that order if you choose.

Mr. DENNING. I congratulate all of them.

Chairman STARK. Mr. Gregg.

Mr. GREGG. I have no questions.

Mr. DONNELLY. I have no questions, Mr. Chairman.

Chairman STARK. I would like to address this to both of you. Again, your associations are well known to us here. I wonder if either of your associations have considered either on a volunteer or on a professional basis providing ombudspersons services to your membership or to the public with the proceeds of whatever fundraising activities you are involved in. Mr. Shulman.

Mr. SHULMAN. I guess the problem, Mr. Chairman, is the general resource limitation that we are under, and the fact that we see this as more of a responsibility of the health care providers and the Government. We do on an informal basis of course provide a monitoring responsibility in terms of hospital care. Obviously, when we collect the anecdotes and the letters and the comments from all of our members, we keep that information available to those who need it. But, again, I think from our perspective it comes down to a resource limitation.

Chairman STARK. Mr. Denning.

Mr. DENNING. May I ask Jack Christy to tell you about a pilot project that we have underway.

Chairman STARK. I would be interested.

Mr. CHRISTY. Mr. Chairman, the association is involved in a Medicare assistance project. It is just a demonstration, but the intention is to try and give fellow Medicare beneficiaries information about the system, how it works, what the limitations are, their responsibilities and what to expect.

Mr. DENNING. You recognize just a pilot.

Chairman STARK. As I say, it is difficult to know how extensive a program like that would be, how one would direct it, and who would staff it. I am sure that is what led us to not be able to figure out how to include it in our bill. It seems to me that there is a need. There is a piece missing somewhere, and the administration, for instance, has argued that providers shouldn't be allowed to represent beneficiaries in appeals under part A because of a possible conflict. Is that valid or isn't it?

Mr. SHULMAN. Janet, why don't you comment on that?

Ms. MYDER. We disagree with that position, because we think that, one, the providers are in a far better position in most respects to understand the system, and as representatives of the patient, they have more of the expertise and knowledge of the program. Beneficiaries have considerable difficulty, as we have already mentioned. Some of them don't even know that they have appeals rights, so it is very helpful and beneficial, I think, to the Medicare beneficiaries to have providers assist them.

Chairman STARK. Do you agree, Mr. Denning?

Mr. DENNING. I want to make one notation here, that we have provided a booklet that tells the patient of his rights, and we try to make that available rather broadly.

Mr. CHRISTY. We have published 500,000 of those booklets, and they are around the country, "Know Your Rights." I think this is a red herring. Up until about 18 months ago, maybe a little longer, providers could represent Medicare beneficiaries. The conflict was discovered a very short time ago, and when you press the administration to define the conflict, they are hard pressed, so I think that there is no doubt that providers can represent beneficiaries, if the beneficiary is willing to nominate them as their representative.

Chairman STARK. If you give them a bill of rights in big type, in one-syllable words, and repeat it, do you really believe that the beneficiaries are going to understand their rights to appeal, and that knowing that, that they are still going to be in a state of mind or feel like protecting themselves? I don't know, what do you do if you are in the hospital and they say get out? You can go back and appeal later, but if you are standing out in the street in your pajamas, that doesn't give you much comfort. Maybe next week you can come back and raise a fuss. Or is it against the law? If I am in the hospital and I say, "I ain't leaving," can they throw me out?

Mr. DENNING. I think you are addressing the problem after the fact. We are trying to get to it before the fact. We are trying to educate the older people, Medicare recipients, of their rights before they ever have the problem or get into the situation that you have reference to, and that is the reason we are putting out the bulletin.

Chairman STARK. What are my rights? If I am in there and I don't want to leave, can they pick me up and wheel me out?

Mr. DENNING. You have got that appeals process to go through, if you know your rights.

Chairman STARK. Wait a minute, I have got the right to appeal before they kick me out; is that what you are telling me?

Mr. DENNING. Right.

Chairman STARK. If I say I appeal, they are going to let me stay in?

Mr. CHRISTY. Your rights to appeal does not actually attach until you are notified in writing that they intend to hold you financially responsible if you don't leave. At that point your approval rights attach, and if upon receipt of that notice you notify the PRO that you intend to appeal, they have got to respond to you in 3 working days.

Chairman STARK. I can stay and eat their food?

Mr. CHRISTY. For just 2 calendar days. You see, if they gave you the notice on a Friday, your 2 calendar days run out Sunday, but of course they have 3 working days to respond, so it is not until next Wednesday that they are responsible to respond to you, and therefore——

Chairman STARK. We take care of that in the bill, right?

Mr. CHRISTY. Yes, you do.

Chairman STARK. So, basically what you are saying, then, is somebody in the hospital, if they know, can stay there, and say, "Hey, you can't just turn me out"?

Mr. CHRISTY. For 2 days they can stay there as a grace period. After that it is on their time.

Chairman STARK. They have got to pay. As a practical matter, do hospitals just shove them out?

Mr. CHRISTY. I think as a practical matter they do basically shove them out. If you are a very squeaky gate, you might stay a little longer, but eventually you leave. I recall a letter we got from a nurse in Texas who refused to leave. She had a high temperature and she said, "I am not going home until my temperature is at least normal for 24 hours." And they brought in every administrator and head nurse to bully her, and she held her ground until her temperature was normal and then she went home.

Mr. SHULMAN. I would want to add to that discussion the fact that I think there are always going to be difficulties for people in understanding their rights and feeling empowered enough to exercise those rights. The health care system for an individual of any age is an intimidating process to have to go through, and I think we have to recognize that basic fact. Really no matter what we do, there has got to be others involved in the process of representing these people.

Chairman STARK. Thank you both very much for your testimony. We look forward to working with you as we work on this legislation.

Our next group is a panel consisting of Jack Owen, executive vice president, American Hospital Association; William Moncrief, American Medical Peer Review Association; Dr. F. Warren Tingley, president-elect of the American Society for Internal Medicine; and Ms. Mary Long, member of the board of directors of the American Nurses Association.

I will just call on you in the order you appear on the witness list, and ask you to summarize or expand on your written testimony in any manner you are comfortable.

Jack, would you like to lead off?

## STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman. You have a copy of my testimony. I would like to just summarize it and go through some points in the bill.

First of all, I am here in support of the concept of the Medical Quality Protection Act of 1986 and applaud you for looking at quality assurance. We have been saying for some time that access and quality were some of the biggest concerns we have had in the program, as you know.

I am sorry that there are so many allegations that hospitals have overreacted to the prospective pricing incentives, because its idea was to save money. We have done that, and done a very good job at it. We see no evidence of wholesale deterioration of the quality of services furnished to the Medicare beneficiaries.

In fact, the Health and Human Services and the inspector general found that a scant 1.4 percent of the cases targeted for further review were identified for further study, so there really hasn't been that much of a problem out there.

Length of stay has been decreasing, and we all know that. Although I might report that the rate has slowed in the last quarter; our 1985 statistics actually show a small increase in the length of stay. The purpose of the prospective pricing system was to gain efficiency and use fewer resources, and that is what we have been able to do. I hope that when the length of stay increases somewhat, that we won't be back here trying to explain why the length of stay is going up.

Chairman STARK. You say the length of stay didn't go up very much?

Mr. OWEN. Well, it has been going down considerably.

Chairman STARK. But has it gone down a lot more in the last year?

Mr. OWEN. The last quarter of 1985, our statistics show that it has leveled off and has in fact gone up a portion of a percentage.

Chairman STARK. This is off the subject, but what drove the kicking up of the deductible from $492 to $500 something? Is that a direct function of length of stay?

Mr. OWEN. No, that is because when we moved to the DRG system from the old cost reimbursement system, what you did was you took the total number of days and divided the total hospital costs, and that was a per diem cost.

Chairman STARK. I understand that.

Mr. OWEN. And that was crazy. They should have stopped that when we went to DRG's and put a percentage of the DRG price, because no one pays——

Chairman STARK. I guess we thought that going from $400 to $492 pretty much swallowed the change in practices.

Mr. OWEN. Correct.

Chairman STARK. And we did get kind of blindsided by this next increase. I wondered if that is directly related to shorter stays?

Mr. OWEN. That is correct.

Chairman STARK. It is?

Mr. OWEN. Yes.

Chairman STARK. Do you think that will continue to $800 or $700?

Mr. OWEN. No, I think that we reach a point where the length of stay is going to level off.

Chairman STARK. I am sorry to interject that.

Mr. OWEN. That is right. I would just like to say that some of the beneficiary complaints that we have heard are about perceived problems, and I won't go into that because that is one of the problems that we have—the difference between what is perceived and what is real. I might mention, however, that the current benefit policies we have were developed 20 years ago, when acute inpatient care was the major area of care, whereas today it is primarily outpatient. We heard Dr. Young from ProPAC talk about this, and I needn't go into it any more.

Let me take a few minutes to talk about the bill, and in particular where we think there might be some changes. First, in the area of refinements to DRG's and resources required by patients—the study of that—severity of illness, and whether the differences are ones of efficiency or of patient needs. We have been saying, and I have been up on the Hill over the last 2 years saying, that something must be done with the national rates, that we should have a blended rate using a coefficient of variation, and that is possible. It is being used in New Jersey. It is not something new, and we think that should be looked at again.

We also agree with Congressman Rangel that the proposed January 1, 1988, date should be brought forward. There is no reason to wait that long to make some changes.

On enhancing the beneficiary's understanding of the Medicare Program, we agree with that wholeheartedly. We worked with the Committees on Aging, the AARP and other groups to make sure that there was some language that was available to hospitals to let

patients know what their rights were. However, I think there also need to be some highlights on the limitations of Medicare coverage to the patient.

Remember that hospitals do not establish the limitations. The Medicare Program does and Congress does, and if there are limitations on benefits and days, they should be spelled out so that the hospitals are not the ones that are blamed.

We believe that the 2 days are sufficient for patients to arrange for postdischarge care, and 3 days are inconsistent with other parts of other programs that are now in effect with the PRO.

On the physician incentive plans, as far as that is concerned, we don't disagree with what is in the bill. If there are some physician incentive plans that make the program look like it is doing things that are wrong, they should be stopped. However, we see no evidence to date that the physician incentive plans that are in effect have yet led to any inadequate care.

On the hospital quality assurance, major revisions proposed in 1983 seem to us to be taking care of this and there is not a need for further study, and as Mr. Daub mentioned, we have got plenty of studies out there already.

On the administratively necessary days, we don't like the idea that these should be budget neutral, and we think that should be struck from the bill. The administratively necessary days are good to have in there, but we are already getting limitations on Medicare payments, and if these are going to reduce the acute care payments, we have an additional problem. Why not, if they are necessary, make them part of the payment structure.

On access to appropriate post-acute care, and required discharge planning, we have no problem with that. We are concerned, however, that in the bill the results of the discharge planning evaluation must be revealed to the patient. Some of that information acquired in the investigation might be a little bit sensitive. While we certainly agree that the final discharge plan itself should be discussed with the patient, we raise questions about sharing some of the evaluations of home life, et cetera, that led to the final plan.

On the waiver of liability, hospitals operate under a great deal of uncertainty. Coverage criteria are not clear cut. It is wrong to punish a hospital when it may be erring on the side of safety by admitting someone, and we think that that waiver of liability should apply to hospitals as well.

On the expedited claims processing, we think that should also include hospitals. PRO appeals we support that, and the quality report on the quality assurance, we think HHS should also investigate the impact of policies. For instance, when they say all or certain kinds of DRG's should be done on an outpatient basis, we have to take into account frequently the living conditions of the patient, where they are coming from.

On readmission review, we would like to see the 15 days rather than 31 days, because we think you are going to pick up a lot of chronic illness on the 31 days. What we have to be looking for is readmissions on a quality basis and 15 days would do it.

I would close with that, Mr. Chairman. We commend the efforts of the Congressman for this legislation. Focus on quality is necessary, and I personally look forward to working with you and the

committee. I would just say, Mr. Chairman, I say that even though I understand at your press conference that you felt strongly that if hospitals did something bad, that the administrator, the doctor, and their Washington representatives should go to jail. I still want to work with you.

Chairman STARK. Along with the Member of Congress.

[The statement of Mr. Owen follows:]

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STATEMENT
OF THE
AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
ON
THE MEDICARE QUALITY ASSURANCE ACT OF 1986

April 23, 1986

## INTRODUCTION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA) and Director of the Washington Office. On behalf of the 5,600 institutional and 40,000 personal members of the Association, I am pleased to be here to discuss the Medicare Quality Assurance Act of 1986.

A great deal of public attention has been directed in recent months to the question of whether the quality of hospital care has deteriorated under Medicare's prospective pricing system (PPS). It has been alleged that hospitals have overreacted to PPS incentives by discharging patients too soon. Much of the proposed legislation addresses various dimensions of the problem perceived to be created by PPS' goals for efficiency.

There is no evidence of wholesale deterioration in quality of medical services furnished to Medicare beneficiaries. Even the formidable resources of the Peer Review Organizations have uncovered very few cases of "premature discharge," or inadequate hospital care. In its recent review of PRO activity in this area, the Department of Health and Human Services (HHS) Office of Inspector General (IG) found that a scant 1.4 percent of cases targeted for review were identified for further study, and that of the 80 percent of these that the IG considered "premature" discharges, at least 97 percent came about at the express direction of the patient or the patient's physician.

There is no question that the average length of hospital stays has been decreasing, a trend that began before implementation of PPS. But the rate of decrease slowed steadily throughout 1985, and in the last quarter of 1985 the average length of stay for elderly patients actually increased slightly. Despite these trends, and because of the dearth of available covered skilled nursing care, it appears that hospitals are providing much sub-acute extended and transitional care--without any additional payment from the Medicare program.

The beneficiary reports that have fueled the debate on deteriorating quality reflect two distinct categories of complaints--there are those who believe that they have received inadequate acute hospital care and those who have been unable to obtain needed post-hospital care. Underlying both types of complaints is a great deal of confusion and frustration among beneficiaries over the unrealized expectation that the Medicare program will cover all their health care needs, something Medicare was not designed to do.

The proposed legislation takes three broad approaches to improving the quality of care furnished to Medicare beneficiaries.

- Improve the quality of hospital care by modifying PPS to help minimize the risk to beneficiaries of premature discharge--without jeopardizing the positive incentives for cost control established through PPS--and by expanding hospital quality assurance requirements;
- Expand the availability of post-acute care; and
- Expand the quality assurrance role of the PROs.

Comments on specific provisions of the legislation are detailed below. Although the legislative proposal has accurately identified the three dimensions to the quality concerns now confronting the Medicare program, and proposes several provisions that are a step in the right direction, there is an important omission in its treatment of the problem of covering and coordinating hospital and non-hospital care.

Current Medicare benefit design and payment policies do not reflect the complexity and diversity either of patient needs or of the providers available to meet these needs in today's environment. Current benefit policies were developed over the past 20 years from a system of cost-based payment and an approach to the practice of medicine that was oriented toward acute inpatient hospital care. In a few short years, we have moved dramatically away from both. Hospitals are still the single most expensive component of medical overall expenditures, but the emphasis is moving away from hospital treatment.

One effect of PPS has been to call attention to the existence of many different levels of medical need both within and between the categories of "hospital," "skilled nursing," and "home health" care. The ability to substitute alternative settings for hospital care as a result of technological advances requires a reassessment of the Medicare benefit, including restrictions--e.g., the three-day prior hospitalization rule for access to skilled nursing services--on access to non-hospital care. Appropriate changes in the Medicare benefit could promote use of alternatives to hospitalization at the same time they could enhance availability of post-acute care.

Among the more important issues raised are the need to establish medical review criteria differentiating between levels of care, identification of providers capable of delivering each level of care, and assurance of continuity of care across levels.

## QUALITY IN ACUTE HOSPITAL SETTINGS

### Refinements to PPS

Because PPS establishes a price per case according to diagnosis and procedure, providers are given incentives to produce and use hospital services efficiently. Theoretically, hospitals that do well under the system are those that can lower costs and operate more efficiently. Efficiency can be improved by increasing productivity, thereby decreasing costs of services, as well as through increasing clinical efficiency by shortening average length of stay and decreasing use of marginal services. This was the intended result of PPS. If this intended result is to be achieved, the Diagnosis Related Group (DRG) system must accurately reflect costs of treating Medicare patients. The AHA has expended considerable energy in an effort to call attention to the limitations of DRGs and to develop methods of setting prices that will not penalize hospitals for treating severely ill patients.

Because HCFA has never been able to demonstrate that DRGs do, in fact, adequately reflect the resources required by patients for the treatment of their illnesses and injuries, the question is now raised whether reductions in cost that have been achieved by hospitals in the past two years are the result of increased efficiency or of a reduction in the provision of needed services. This bill calls for HHS to develop and submit a legislative proposal to refine PPS to assure that prices approximate the cost of efficiently provided and medically necessary care, and to account for severity of illness. We would wholeheartedly support an attempt to refine the DRG classification system so fair payments are made for the treatment of well-defined and homogeneous groups of patients. The efficiency goal of PPS can only be appropriately met when assumptions underlying the incentive structure--that payments will be based on averages defining uniform groups of patients--are met. The proposal to require the Secretary to study DRGs is a step in the right direction, but it does not go far enough.

In developing its proposal, HHS should be required to demonstrate whether differences in average costs among hospitals stem from differences in efficiency, in which case they are not a cause for concern, or from differences in patient needs. If HHS finds that cost differences are not due to differences in efficiency but to the treatment of different kinds of patients, a further step should be taken.

The AHA encourages exploration of ways to account for severity of illness in the DRG classifications, but given the practical limitations of existing severity indicators, AHA recommends that Congress give serious consideration to alternative methods for more accurately pricing services. The AHA believes that its DRG-specific price blending proposal is the best and most immediately accessible solution to the problem of accounting for severity. The AHA is currently examining other solutions to compensate for the defects of DRGs and to create positive incentives for the treatment of patients with unusually high medical needs (e.g., outlier price adjustments) and encourages Congress to do the same.

The proposed legislation sets a January 1, 1988 deadline for the HHS report. This should be moved up to 1987. On January 1, 1988, fully two thirds of all hospitals will be paid at uniform national rates, the remaining third to follow within six months. By this time the ill effects of inadequate compensation will already be keenly felt. Since there are feasible alternatives such as the AHA proposal that could be implemented quickly, and because of the urgency of the problem, the earlier date is preferable.

Enhancing Beneficiary Understanding and Appeals

As noted above, one of the important causes of beneficiary complaints is wide misunderstanding by both beneficiaries and providers of the DRG-based system, the scope and limitations of Medicare coverage for hospital and post-hospital services, and the beneficiary's rights to appeal hospital and PRO coverage decisions. The legislation proposes two amendments to the Medicare statute that would increase beneficiary understanding of Medicare coverage determinations and appeals.

First, it would require hospitals to distribute notices informing beneficiaries about their rights to hospital and post-hospital services. An existing provision in the regulations governing the PRO program led to the development (by AHA, other providers, beneficiary groups, and the Aging Committees) and distribution of a similar "Message from Medicare" that hospitals were instructed to distribute to all Medicare patients earlier this year. AHA agrees that the inability of beneficiaries to obtain clear, coherent information from Medicare is a significant problem and has cooperated with HCFA and congressional staff to make such information available.

In describing the beneficiary's rights, the Secretary should also be required to highlight the limitations of Medicare coverage imposed by the Medicare statute for hospital and post-hospital extended care services, as well as administrative limitations imposed by the Medicare program (e.g., limitations on access to acute hospital care through PRO-established acute care criteria). Hospitals, after all, do not establish such limitations; Medicare does.

To enhance beneficiary understanding of Medicare appeals, Sec. 103 would incorporate existing procedures under PPS regulations for hospitals and beneficiaries to obtain a PRO review when the hospital determines that continued in-hospital treatment is no longer necessary. The proposal would: clarify that the patient has the right to a PRO review of the hospital's determination; shorten from three working days to three calendar days the amount of time the PRO would have to perform an expedited review requested by a beneficiary who is still an inpatient; and expand to three days the time a hospital must allow before billing a beneficiary for unnecessary inpatient care.

We support the clarification of the patient's right to a Medicare coverage determination by the PRO within three calendar days. It is not in anybody's interest to prolong the wait for a definitive Medicare coverage decision on the appropriateness of the discharge, which can only be rendered by the PRO, and which, in the vast majority of cases, will agree with the determination of

the attending physician and the hospital's utilization review committee. The AHA believes, however, that two days are sufficient time for the patient toarrange for post-discharge care. Expansion of the grace period to three days would be inconsistent with past practice under per-diem payment, when Medicare generally allowed one or two days to arrange post-hospital care, and with the PRO law, which allows the PRO to authorize Medicare payment for a maximum of two days for making post-discharge arrangements. It should also be made clear that the additional days spent in the hospital without patient liability are granted only for the purpose of arranging post-hospital care.

Two days should also be sufficient for the PRO to perform its review of the appropriateness of the physician's discharge order. If it is not, then changes in the organization of the PRO program are in order to allow review to be performed closer to the place where care is delivered.

Physician Incentive Plans

The proposal would prohibit certain financial incentive plans intended to encourage physicians to shorten lengths of stay or use fewer services. AHA shares Congress' concern that incentive plans tied to the treatment of individual patients may create pressure to undertreat the most seriously ill patients, but there is no evidence that this has been the result under such plans. However, the AHA believes that current protections against undertreatment in the PRO program are sufficient to guard against inappropriate physician behavior. PRO sanction authority, which is quite broad, allows PROs to impose monetary penalties on physicians who furnish poor quality care, and ultimately to exclude them from participation in the Medicare program. PRO authority over quality has recently been expanded under the Consolidated Omnibus Budget Reconciliation Act of 1986 to allow the PRO to deny payment for quality infractions. Furthermore, the directive to conduct a study of "other such plans," which presumes that any incentive plans result in inadequate care, is a proposition for which there is no evidence.

Hospital Quality Assurance

The proposed legislation calls for HHS to study the adequacy of the Medicare conditions of participation and to report to Congress within two years on the results. The bill summary also states that the committee report will show that Congress' intent is to defer any changes in the conditions that may affect the quality of hospital care until the study is completed.

AHA encourages evaluating the relationship between the conditions and the quality of hospital care. Such evaluations of existing regulations should be done routinely, and in the case of the conditions of participation, Medicare periodically does just that to assess the "deemed status" granted to those hospitals accredited by the Joint Commission on Accreditation (JCAH). On the basis of a substantial reevaluation undertaken several years ago, Medicare concluded that major revisions were necessary, and these were proposed in 1983. Public comments on the proposed revisions have been under intensive review for more than three years.

These revisions in their final form contain a new quality assurance standard that would require hospitals to perform discharge planning, a function that is not currently required and that the bill proposes to establish as a required hospital function. We would strongly oppose any attempt to restrict promulgation of the proposed revisions to await a study that has, in effect, already been completed.

Hospital Provision of Extended Care Services

The bill would require HHS to study the treatment of "administratively necessary days" (ANDs), days spent in the hospital awaiting placement in a skilled nursing facility (SNF). The study would determine the extent to which current prices include and adequately reflect the actual costs of providing these services and whether additional payments should be made for them. The bill calls for any additional hospital payments to be "budget neutral."

References to making any additional payments "budget neutral" should be stricken. Over the past two years, inflation on the one hand and the inadequate Medicare price increases on the other have confronted hospitals

with a real decline of 8 percent in payment levels. Additional amounts for ANDs cannot be wrung out of existing payments. The provisions should say simply that payments will be made under Title XVIII and will be separate from per-case and any outlier payments. The AHA suggests that payments be based on the SNF rate for additional days of non-acute services.

Current HCFA policy prohibits hospitals from issuing notices of noncoverage to inpatients who are not at an acute level of care but are awaiting placement in a SNF. As a result of the increasing scarcity of available Medicare-covered SNF services, hospitals are more often keeping patients in the hospital who do not need acute care, without any additional payment by the Medicare program. This provision should be expanded to require the Department to consider ways to enhance the ability of hospitals to furnish post-acute services while ensuring payment for any additional services hospitals may provide.

## ACCESS TO APPROPRIATE POST-ACUTE CARE

### Required Discharge Planning in Hospitals

Section 201 would make discharge planning a required hospital function (like utilization review, a part of the definition of a hospital). It would require the Secretary to develop guidelines and standards for discharge planning, and specifies how the function should be structured.
The AHA has long encouraged the development of effective discharge planning programs. Discharge planning can improve the quality of patient care planning, improve the efficiency of the provision of hospital services, improve the continuum of care, and assure appropriate discharge placement. However, there are some problems in the proposed legislation.

- The proposal suggests that the discharge planning evaluation would focus only on the need for appropriate Medicare-covered post-acute services. However, hospitals perform discharge planning for all post-hospital needs (i.e., including need for ICF services, which Medicare does not cover, as well as Medicare-covered SNF services).

- The proposed Sec. 1861(ee)(2)(B) calls for revealing the "results" of an "initial discharge planning evaluation" to the patient. Because of the lack of clarity in the definitions, this provision could be interpreted broadly to include the revelation of sensitive assessments of the patient's home life that enter into the discharge plan. The patient should by all means be involved in the planning for his post-discharge care, but it would be more appropriate to refer here to the "discharge plan" or the conclusions drawn from the evaluation regarding the proposed disposition of the patient.

- Proposed Sec. 1861(ee)(2)(G) would require that the initial discharge plan be developed by a registered nurse, social worker, or equivalently trained personnel. The AHA opposes specifying qualifications in the law that would have the effect of restricting hospital flexibility and therefore limiting the ability of some hospitals to provide these essential services. We would prefer a requirement that the plan be developed by a person qualified by experience or training to perform discharge planning.

### Waiver of Liability

AHA understands the reasons for maintaining a measure of security under the waiver of liability provisions for home health agencies (HHAs) and skilled nursing facilities (SNFs). The waiver of liability provisions in Sec. 1879 of the Act protect beneficiaries and providers from financial liability when it is determined after the fact that services rendered would not be covered by Medicare. The proposed provisions would prevent the implementation for HHAs and SNFs of new administrative procedures that have been adopted for determining whether hospitals should be paid under the waiver. Such procedures are expected to erode the protections intended by the legislation.

Hospitals, too, currently operate under a great deal of uncertainty regarding Medicare coverage and payment for services that the hospital has already, in good faith, provided. If Medicare coverage criteria were clear cut, the

waiver would serve little purpose. But the coverage issues decided by the PROs are anything but clear cut, as evidenced by the wide discrepancies between what the "SuperPRO" (an organization contracted to review the accuracy of PRO decisions) and the PROs believe appropriate. When this uncertainty is coupled with severely diminished access for hospitals to the waiver of liability, hospitals bear a significant financial risk for erring on the side of safety, for choosing to admit when coverage may be in doubt. If Congress wishes to change incentives to add further protections for beneficiaries, it should reinstate the use of the favorable presumption to preserve a safety margin for hospital errors in coverage determinations as well.

Uniform Needs Assessment

Proposed Sec. 204 would require HHS to develop a "uniform needs assessment instrument." We have no objection but would urge that such an instrument be developed for the optional use of providers and that the advisory panel formed for HHS consultation in developing the instrument include hospital representation.

Expedited Claims Processing

Secs. 205 and 206 would expedite the handling of claims by fiscal intermediaries and would assure prompt responses by the Medicare program to beneficiary inquiries regarding the exhaustion of their skilled nursing service benefit. We would support these provisions but recommend that they be extended to cover hospital services as well as skilled nursing services.

PRO Appeals

The AHA enthusiastically supports Sec. 207, which would allow providers to represent beneficiaries in their appeals of Medicare coverage decisions, and would allow providers and practitioners to appeal administrative or technical denials and any other denials of Part A claims. We hope it would be clarified to indicate that providers and practitioners should have access to appeal any payment determination beyond the reconsideration by the PRO.

Reports on Quality Assurance

In expanding the scope of HHS' annual reports on PPS to include information on quality and accessibility of post-hospital services, the AHA suggests that Sec. 208 be amended in two ways. First, the report should require an assessment of the role hospitals should play in meeting the needs of beneficiaries for post-acute care. Second, in its review of the impact of PPS on the quality of patient care, HCFA should be required to investigate broadly the impact of PRO review and coverage policies on the quality of services available to Medicare beneficiaries. For example, PRO contracts have placed a great deal of emphasis on treating certain medical conditions on an outpatient basis; at the same time, HCFA has adopted a policy not to allow PROs to consider social factors like the availability of family support at home or the distance of the patient's home from the facility in making admission decisions.

IMPROVED QUALITY REVIEW BY PROs

Data Submission

Sec. 301(a), which would amend Sec. 1153 of the Social Security Act to require hospitals to supply data directly to PROs to expedite the review process, is unnecessary and would be wasteful and counterproductive. There is no need for a separate data collection cycle for use by PROs, since all of the information they need to initiate review can be obtained through the billing process. Current problems in the timing of PRO review are generally the result of poor data coordination between the PROs and the fiscal intermediaries. This provision should be revised to bind the fiscal intermediaries to more timely submission of data to the PROs.

Readmission Review

During the first two years under PRO review, PROs have been required to review all cases of readmission within seven days of a prior hospitalization. According the the HHS Office of Inspector General, which recently investigated this review activity, only 1.4 percent of those cases reviewed were found worthy of further study. Only 60 percent of these--less than 1 percent of

readmissions reviewed--reflected potential quality concerns. Researchers looking into Medicare readmissions have found that they are often the result of chronic illness among the Medicare population, and often reflect the unmet need for supporting social services outside the hospital. For example, surgery patients were found less likely to be readmitted, while the disabled, Medicaid-eligible, and rural beneficiaries are more likely to be readmitted.

Sec. 301(b) would require PROs to review readmissions within 31 days. This is far too long a period to capture true cases of "early readmission." While existing evidence strongly suggests a need for discharge planning, it does not suggest that readmissions are linked to widespread quality problems. It is unlikely that casting a broader net than that proposed for the next PRO contract period--PROs will review all readmissions within 15 days of hospitalization--will do anything more than highlight the need for Medicare to address the special problems of its chronically ill beneficiaries. If readmission review is to be required, readmissions within 15 days would adequately capture cases of "early" readmission.

Redefining Quality

Under current PRO regulations, as directed by Congress in the PPS amendments, the PROs review the adequacy of care and the appropriateness of discharges under PPS. HCFA has already announced that its plans for the next generation of PRO contracts call for more direct attention to these issues. In addition, the recently enacted Section 9403 of P.L. 99-272, (COBRA), allows PROs to deny payment for services which the PRO determines are of substandard quality. Given these developments, Sec. 302, which would further clarify that quality review by PROs includes review of the adequacy of care, and would require hospitals to assure the provision of necessary care, would seem not to be necessary.

Responsiveness to Beneficiary Complaints

Sec. 304, which would improve PRO responsiveness to beneficiary complaints, should be applied to hospital complaints also.

Data Disclosure by PROs

Sec. 305 would expand the list of organizations with access to information held by PROs on providers or practitioners beyond the state and federal agencies currently entitled to PRO information under Sec. 1160 of the PRO statute. The Secretary would appear to have broad discretion in determining who meets the definition of "State ombudsmen and State protection and advocacy officials" who would be eligible under the proposed legislation to receive confidential PRO information. Given the uncertainty as to precisely who would be entitled to receive this information, we would oppose this provision since it does not offer adequate confidentiality protections. PROs are already required to share information with state licensing and public health agencies, and are free to make public their conclusions about the quality of care in any hospital as long as they do not release confidential quality information.

CONCLUSION

In closing, Mr. Chairman, the AHA wishes to commend the efforts of both of the primary sponsors of this legislation in their attempt to focus attention on the operation of Medicare PPS and its relation to quality of hospital inpatient care, as well as the availability of covered post-acute care for Medicare beneficiaries. We look forward to working with the Subcommittee to modify certain portions of the bill so that it will lead to improvements in PPS for both providers and Medicare beneficiaries.

Chairman STARK. Dr. Moncrief, why don't you proceed.

**STATEMENT OF WILLIAM MONCRIEF, JR., M.D., VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION, AND PRESIDENT, CALIFORNIA MEDICAL REVIEW, INC.**

Dr. MONCRIEF. I am Dr. Bill Moncrief, a practicing physician in San Francisco, Congressman Stark; vice president of the American Peer Review Association, which is the national association of physician-based peer review organizations, and also president of your PRO.

Chairman STARK. Right.

Dr. MONCRIEF. The California Medical Review—CMRI. I certainly appreciate the opportunity, Congressman Stark, to present testimony. I will be brief. We have submitted formal written testimony to be included.

I would like to make two generic comments. One has to do with the continuum of care situation that we have in delivering health care, which the legislation appropriately addresses. I, quite frankly, describe this as very much like one of the circus balloons, one of the long, hotdog balloons that you can get. The PPS system has squeezed one part of that balloon, and it has pushed out into both ends, the prehospital arena and the posthospital care resources. It has impacted in both of these areas, and I think your legislation appropriately addressed this.

The other point I would like to make is that in section 302 you have raised the point asking the PRO's to accept the responsibility for review of acute posthospital care in nursing homes, HMO's. We have this authority now. The problem is that we don't have the legislative, the explicit legislative intent that says: "Do it and here are the dollars to do it with."

Chairman STARK. I suppose you would like both at once?

Dr. MONCRIEF. If you give it to us both at once, we will take them both at once, sir.

I would like to address a couple of questions that have come up in previous testimony. I have been on several panels with Bart Fleming, and I can appreciate the administration's comments about the adequacy of funding. I would like to point out that the first round of contracts were very proscriptive, gave very little flexibility to the PRO's, and emphasized utilization.

The hospitals have done a very good job in utilization, and most PRO's are in the quality review business now in acute inpatient care, and this is much more expensive. There is no question about it.

The first 14 sanctions that we forwarded to the Office of the Inspector General from California, which included 2 hospitals and 12 physicians, we sent a bill to HCFA for $1.5 million.

Chairman STARK. What happened to the 14?

Dr. MONCRIEF. They have all been accepted.

Chairman STARK. I mean were they penalized, put out of business?

Dr. MONCRIEF. Of course you realize the sanction process gives two penalties: One, exclusion from the Medicare Program, the other a financial penalty. We have recommended that a hospital be

excluded from the program, and the Secretary has agreed to that. The first three physicians that we recommended, one exclusion from the program, the other two were monetary penalties, and those have been accepted by the Secretary.

Chairman STARK. It seems to me I read the other day that a hospital in San Leandro is going to lose—that is State procedure.

Dr. MONCRIEF. That is under the conditions of participation, and not PRO sanction.

The other point that I bring up is quality review is more expensive. It is much more expensive, and in the second round, the emphasis is on quality, and I don't think the PRO's that I know of can afford to do what HCFA wants us to do in this next round, emphasizing quality with a reduction in funds from 1984.

Chairman STARK. Are you suggesting that quality review is a more subjective area? It requires more judgment?

Dr. MONCRIEF. Yes. It involves a lot of physician time. For us to develop a sanction, to get a sanction to the board of CMRI takes about 30 M.D. man-hours, to get it to the board.

Chairman STARK. And if you use neurosurgeons, that is about five times as expensive as using pediatricians.

Dr. MONCRIEF. We, unfortunately, don't pay neurosurgeons any more than we do an internist, a more "cognitive profession."

Mr. Rangel asked what is being done in quality regarding premature discharges. We have recommended to the Secretary sanction against a hospital where we discovered inappropriate premature discharges. And so the PRO's are moving in this area—in the quality area—and premature discharges represent a quality issue. I am glad to say that nearly every PRO in the country is moving positively in this direction.

Congressman Stark, you asked about the incentives for M.D.'s, and this probably comes from a corporate entity in California with a series of hospitals that offered financial incentives to the physicians for discharging the patient before the DRG trim points. We have monitored the eight hospitals that this particular corporation has responsibility for, and we have not found quality issues in this particular series of hospitals. It is something that we are acutely aware of.

You have asked a couple of questions about the ombudsman program. I would say that my experience in California is it is spotty, and before we change it, I would like to see it working as it was intended to work, and see if it is appropriate, see if it works efficiently and effectively, and then make recommendations regarding change. But in most places it doesn't have the resources to work as it was intended to work.

[The statement of Dr. Moncrief follows:]

STATEMENT OF WILLIAM MONCRIEF, JR., M.D., VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION [AMPRA]

EXECUTIVE SUMMARY

1. The American Medical Peer Review Association (AMPRA) is supportive of the Medicare Quality Assurance Act of 1986. The act is responsive to growing concerns regarding the quality of patient care and will help restore public confidence in the Medicare Program.

2. AMPRA believes, however, that any Medicare quality assurance system will be limited by the present inadequacy of the post-acute care benefit and the absence of a medicare long term care policy. No quality assurance system can take the place of needed benefit coverage made more pronounced by the impact of Medicare prospective payment (PPS). AMPRA urges Congress to redesign medicare benefit coverage in recognition of changing patient demands and to serve as the underpinnings of a realistic quality assurance program.

3. AMPRA is generally supportive of the PRO related provisions as specified in the act. We are concerned, however, with any expansion of PRO activities without a corresponding increase in program dollars.

4. AMPRA believes that the language of the act is ambiguous concerning the legislative intent to expand PRO review services in the post acute setting, ambulatory setting, and in HMOs. At a time when Medicare prospective payment (PPS) is driving medical services away from the acute care setting, it is imperative that PRO review extend beyond the hospital door. AMPRA recommends that expanded PRO review become a condition of participation for Medicare providers and that an appropriate timeframe for implementation be established.

Mr. Chairman, I am Dr. William Moncrief, Vice President of the American Medical Peer Review Association (AMPRA), the national association of physician-based medical review entities and the Peer Review Organizations (PROs) under contract to the Medicare program. I am also President of California Medical Review, Inc., the PRO from your home state of California. With me is Andrew Webber, Executive Vice President of AMPRA. We appreciate your invitation to present our comments and recommendations on H.R. 4638, the Medicare Quality Assurance Act of 1986.

As an organization deeply committed to the value of vigorous quality assurance activities and accountable for monitoring the quality of inpatient hospital care provided to Medicare beneficiaries, we are gratified by your interest in and support for our efforts as reflected in this legislation. We, too, have been concerned about the effects of new financial incentives on the quality and accessibility of medical services to older Americans. While at this time we do not detect any systematic pattern of inadequate or substandard care in the acute care setting, there is a very real need to expand our capacity to assess the quality of services in the rapidly growing post-hospital delivery system and in ambulatory service settings, including Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) under contract with Medicare.

All of us are aware of the significant shift in the locus of Medicare services. Hospital use has declined dramatically and the volume of ambulatory services has risen, with particularly large increases in referrals to skilled nursing and home care providers. As more and more Medicare beneficiaries obtain services outside the inpatient arena and as large numbers enroll in managed care systems, the importance of extending quality assurance programs to these settings becomes more urgent. In sum, we very much need to develop and implement comprehensive quality and utilization assessment tools that are capable of evaluating services across the continuum of care. Movement by Medicare toward greater reliance on capitated systems will depend on progress in these areas.

We believe your bill includes an agenda of steps that can be taken to move us forward toward a more integrated approach to quality assurance and identifies certain mid-course corrections to our present payment and coverage policies that can minimize the potential for compromises in the quality of care or gaps in the delivery system. We believe that quality and cost-effectiveness can and must be complimentary objectives.

Congress must recognize, however, that an improved quality assurance system cannot substitute for the need to improve Medicare benefit coverage, particularly in the post acute care setting. At a time when Medicare prospective payment has stimulated demand for nursing home, home health, and custodial care services, Medicare benefit coverage has remained inadequate. If Congress is serious about maintaining the quality of patient care, the need to redesign Medicare benefit coverage cannot be avoided.

AMPRA would also be remiss, Mr. Chairman, if we did not suggest that your bill will require an expansion of PRO activities and resources. Much of the design and developmental work on new review methodologies and the creation of new data bases remains to be accomplished. Enlargement of the scope of peer review functions combined with additional responsibilities to assist beneficiaries resolve complaints suggests the need for additional financial resources.

Our experience with earlier expansions of PRO functions has caused us to be apprehensive about the provision of adequate financial support to meet our new obligations. AMPRA cannot escape pointing out that the PRO program budget repre-

sents only one tenth of one percent of the Medicare hospital trust fund. We are especially concerned that the promise of this legislation that Medicare services meet rigorous standards of quality is fulfilled. Without adequate resources that promise will be a hollow one for the beneficiaries of the program.

PRO-RELATED PROVISIONS

Now we would like to focus our comments on those provisions of your bill that specifically expand the activities to be carried out by PROs. First, the bill would impose new reporting requirements on hospitals to submit data necessary to facilitate medical reviews. While we understand that this provision would not overhaul the present system of data exchange between Medicare fiscal intermediaries and PROs, it would assist PROs in establishing their potential review universe for every institution. This would aid PROs in anticipating review volume for a given period and increase the ability to evaluate PRO efforts on a more timely basis. AMPRA is supportive of this provision.

AMPRA supports the expansion of readmission review from the present 7 day requirement to within thirty days of previous discharge. Expanded readmission review will not take the place of PRO authority to monitor the quality of patient care outside the acute care setting. Readmissions are, however, a potential indicator of premature discharge and clinical mismanagement and AMPRA strongly encourages this approach. It must be recognized that this is a significant expansion of present PRO efforts which will require additional program funding.

We also want to call your attention to the provision requiring PROs to complete consideration of beneficiary appeals of notices of non-coverage within three calendar days. While we support a prompt and fair appeals process, it may not be possible to complete our reviews in a timely fashion if the necessary ducumentation is not furnished rapidly. Further if the beneficiary appeal is logged at the close of a business week, it may not be possible to complete our consideration within three calendar days. We recommend that the time limit for responding to appeals begin after submission of the necessary data to the PRO and that three working days be substituted for three calendar days. If three calendar days is to be retained, it must be recognized that administrative costs for PROs will increase to maintain PRO operations on the weekend.

We strongly support the provisions in Section 302 of the introduced bill that mandates that PROs concentrate energies on quality review activities. AMPRA is concerned, however, that Section 302 does not make clear Congressional intent to extend PRO review in the post acute care setting, ambulatory setting, and for services provided by health maintenance organizations. While it could be argued that the present law has always granted PRO authority to review services beyond the acute care setting, this authority is hollow absent appropriated dollars and the will of the Administration to move forward. AMPRA recommends that expanded PRO review become a condition of participation for Medicare providers and that an appropriate timeframe for implementation be established in the law. Only then will our present authority be translated into a programmatic initiative. For the reasons cited earlier, expansion of PRO review should be a high priority for the medical review program.

AMPRA is aware that the bill recognizes additional work needs to be completed on the criteria and review methodology appropriate for each of these settings. We support the development of new quality assurance methodologies and the field testing of new instruments on a frequent basis. As always, AMPRA recommends that the budget impact of Section 302 be explicitly recognized by setting aside additional funds for those purposes.

The Act also includes a provision directing PRO involvement in a complaint resolution process for beneficiaries. In some respects, this activity moves our program toward an ombudsman role that could divert significant resources away from medical review functions. We do want to hear about possible quality problems from physicians, hospitals, other health professionals and from beneficiaries and their families. However, we do have some concern that a significant number of complaints may not relate to quality of care issues. Further, we believe that the existing confidentiality regulations may limit our ability to report the findings of our investigations to the complainant.

We strongly support the provisions of H.R. 4638 that allow the sharing of information concerning final determinations by PROs with regard to substandard quality of care by any provider of Medicare covered services. Our experience with the sanctions process is that other regulatory and accrediting bodies are often pursuing the same individuals or institutions that our findings can be helpful in the completion

of their investigation. So long as the information shared represents our final recommendation and preserves appropriately the confidentiality of the process, we feel this provision can assure proper coordination of medical review, licensing and other regulatory activities.

The provision requiring the appointment of a consumer representative to the boards of PROs is, in our opinion, not necessary. A growing number of PROs already include such an individual on their boards in accordance with a policy recommended by AMPRA. However, we do not think it is appropriate for the statute to mandate the board composition of private review organizations. Certainly PROs ought to have the discretion and flexibility to select board members on the basis of the organization's needs and availability of individuals to serve. AMPRA is not opposed to consumer representation on PRO boards; we are opposed to a statutory mandate that dictates board composition for any private organization.

### OTHER PROVISIONS OF INTEREST TO PRO'S

In our review of the remaining sections of the bill, we want to particulary commend your focus on improving access to post-acute services. Our experience to date strongly indicates that gaps in the availability of skilled nursing beds and home health services is a serious problem. Often planning for discharge has not been adequate, but in other cases facilities or needed services are simply not available. The development of new tools to aid discharge planning and mandatory hospital programs can be an important contribution.

AMPRA supports refinement of PPS for hospitals to better account for variations in severity of illness and case complexity. We support this provision not simply to make more equitable the hospital payment system but to introduce new case mix systems that can help monitor and evaluate the quality of patient care. In developing a severity of illness measure for Medicare, AMPRA strongly recommends that the system be based on patient characteristics and clinical findings at or near hospital admission rather than at discharge. Severity assignment at admission would reduce payment inequities, create the right incentives for hospitals and maximize the potential of the severity measure as a quality assessment tool.

As a needed compliment to severity measurement, AMPRA advocates the study of medical practice variation through the conduct of small area analysis by PROs. AMPRA's corporate affiliate, the American Medical Review Research Center (AMRRC) has submitted a prospectus to HCFA and interested foundations to coordinate a broad educational effort involving the research community and practicing physicians in understanding local practice variation.

We would like to suggest that allowing providers to represent beneficiaries in appeals proceedings is somewhat troubling from our perspective. It seems to us that in most instances the provider is in a conflict of interest situation which is difficult to overcome. Since providers that are at risk for the financial consequences of a coverage or payment denial have adequate appeal rights of their own, we do not believe they are appropriate representatives of beneficiaries. In most instances the beneficiary is not liable for non-covered services or when a dispute arises over the payment amount.

In the final title of this bill there are a series of studies on the future of quality assurance mechanisms, the allocation of resources for these purposes and the criteria and methods employed to conduct these activities. These are critically important tasks. We are anxious to participate in and to advise the Department in each of these areas. Improvements to our current approach to reviewing hospital care can be achieved, and much can be learned about cost-effective review of the quality of services in the ambulatory environment. We hope that this work is accorded a very high priority at the Department of HHS without waiting for the enactment of this legislation.

Our comments on this legislation are intended to communicate our general support of the thrust of H.R. 4638. There are several areas as noted earlier where we believe the measure could be strengthened. Overall, our experience with the PRO program during this time of severe fiscal constraints often has been an unwillingness on the part of the Administration to allocate sufficient resources to the tasks at hand.

At the present time PROs are renegotiating contracts for the next two year cycle. We can tell you that the position of HCFA has been to offer the same, or in some cases, fewer contract dollars, despite the additional duties added by recent legislation and experience in many PROs that present funding has been inadequate to do the job. We urge you to include specific funds for the new activities contemplated by

this bill or to indicate those present functions that can be eliminated. Without realistic funding, the critically important role of the PRO program will be compromised.

We want to again express our appreciation for the opportunity to testify at these hearings. Mr. Chairman, your bill contains the blueprint for a much stronger and more comprehensive quality assurance program for Medicare. We are anxious to work with you and this Subcommittee to move these proposals forward.

Should you or other members of the Subcommittee have questions about our testimony, I will be glad to respond at this time.

Chairman STARK. Our staff indicated that maybe there had been something like 3,000 cases of premature discharge that have come before the PRO's. Do you know how those were disposed of?

Dr. MONCRIEF. This comes out of the inspector general's audit?

Chairman STARK. Yes.

Dr. MONCRIEF. And there were some 2,400 I think plus identified, and, to comment generically on the inspector general's audit, that included the greater bulk of pre-PRO activities, PSRO, it included 1983, 1984, and some of the first quarter of 1985. In California we didn't start our contract until October 1, but I think the premature discharge issue we have a special contract with HCFA to look at this. I don't have numbers; we will have this by September or October 1986.

Chairman STARK. Thank you.

Dr. Tingley of the American Society of Internal Medicine, would you like to follow. It is good to see you again.

## STATEMENT OF F. WARREN TINGLEY, M.D., PRESIDENT-ELECT, AMERICAN SOCIETY FOR INTERNAL MEDICINE

Dr. TINGLEY. Good morning. I am Warren Tingley, president-elect of the American Society of Internal Medicine, and an internist in private practice in Arlington, TX.

When the prospective payment system was first implemented, ASIM expressed reservations about the effect diagnosis-related groups might have on the quality of patient care under Medicare.

To better assess the impact of DRG's, ASIM distributed an informal survey to its members which provided evidence that (1) physicians are under considerable pressure to make either premature or inappropriate discharges, (2) DRG's do not reflect the severity of a patient's illness, and (3) PRO's faced with ambitious contract objectives to limit hospital utilization have increased the denial rates of medically indicated admissions.

The present emphasis on cost containment requires physicians to balance the program's strong signal to reduce costs, with the health and financial needs of the patients. This often requires some difficult and unpalatable choices. As a physican, I am aware of instances where patients have not met the PRO criteria for continued hospital care. However, because those patients are not well enough to take care of themselves, did not have an adequate family support system to care for them or did not have necessary nursing care available, it was not medically advisable to discharge them.

In such instances, physicians and their patients are faced with a losing proposition. The physician can either release the patient against his or her best medical judgment, or advise the patient to remain in the hospital, knowing that the patient may not have the money to pay for continued care. If it is denied by the PRO, such care can cost $800 a day or more.

Both situations are detrimental to patients' physical and mental well-being. ASIM commends Congressman Stark and Senator Heinz for sponsoring the Medicare Quality Assurance Act to address many of the quality problems identified with PPS. This legislation will (1) enhance the quality of care in hospital settings, (2) provide for better care of patients, once they are discharged from the hospital, and (3) enable PRO's to better monitor care by practitioners and providers to insure that they meet their legal and professional responsibilities.

ASIM's written statement contains extensive comments on this proposed legislation. I will take this opportunity to highlight areas that we believe need to be strengthened.

ASIM strongly supports provisions in the bill that require closer scrutiny of the quality of medical care under PPS. ASIM, however, would encourage the subcommittee to strengthen section 401 to require the Department of Health and Human Services to implement now a more thorough program to identify and report quality problems under PPS.

Similarly, ASIM——

Chairman STARK. You mean strengthen the study or the language?

Dr. TINGLEY. Strengthen the language.

Chairman STARK. We are only asking for a study there.

Dr. TINGLEY. We are saying now. There is no need to delay. The data is there. We would like that show on the road.

Similarly, ASIM supports greater peer review of the quality issues, such as the review of hospital readmissions within 30 days of a discharge for selected DRG's. However, if peer review is to be conducted in outpatient settings, the Society believes that the bill should specify that such review be directed only to those physicians or facilities that have been identified through professionally developed guidelines as having provided potentially poor quality care.

ASIM also believes a change should be made to the legislation's requirement that PRO's investigate all written beneficiary complaints concerning the quality of care they receive. The Society supports the thrust of this provision, but believes it needs to be clarified to protect confidentiality and due process as explained in our written statement.

Similarly, the Society supports the bill's provisions to require PRO's to share quality concerns with Federal and State officials, but believes that it should be modified to, (1) protect confidentiality of physicians and providers that have not provided poor quality care, and (2) direct information to those State agencies with the legal authority to restrict practice of incompetent providers.

In closing, I reiterate the Society's support for the Medical Quality Assurance Act. Our specific suggestions are for modifications we believe will make the legislation an even more effective vehicle for assuring quality care, while maintaining adequate due process and confidentiality protections.

The Society also emphasizes that it is essential that adequate additional funds be appropriated to the PRO program to help finance the various provisions within this bill. If the PRO program is expanded to a point that it is not financially viable, then the health case of beneficiaries will not be properly protected. The perform-

ance of practitioners and providers will not be properly assessed and the viability of peer review programs will be put in serious jeopardy.

I will be happy to entertain any questions.

Chairman STARK. Thank you, Doctor.

[The statement of Dr. Tingley follows:]

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

BEFORE THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

ON THE

MEDICARE QUALITY PROTECTION ACT

April 23, 1986

Good morning. I am Warren Tingley, MD, president-elect of the American Society of Internal Medicine. As a practitioner of internal medicine from Arlington, Texas, I am pleased to appear before your Subcommittee to express the Society's support for the Medicare Quality Assurance Act and to offer suggestions for how the bill can be further strengthened to protect the health care of beneficiaries.

The American Society of Internal Medicine (ASIM) is an organization of over 20,000 physicians who specialize in internal medicine, many of whom also practice in a related subspecialty. The Society was founded in 1956 to address socioeconomic issues facing the practice of internal medicine. As the major providers of continuing, comprehensive medical care to adults, internists are especially concerned with the health care of the elderly. This morning I will discuss a number of aspects of the Medicare program that we believe need to be addressed by Congress in order to protect the quality of care received by the elderly under the Medicare program. More importantly, I will express the Society's views on how the Medicare Quality Assurance Act will help correct some of the problems currently experienced under Medicare.

When the prospective payment system (PPS) was first implemented, ASIM expressed reservations about the effect diagnosis-related groups (DRGs) might have on the quality of patient care under Medicare. Specifically, the Society was concerned that the system could lead hospitals to (1) underprovide services, (2) skimp on care in order to stay within payment limits, (3) artificially inflate diagnoses to obtain higher payments for the hospital (DRG creep), and (4) provide lower quality of care to Medicare beneficiaries. Because of these concerns, this Society has urged the Secretary of the Department of Health and Human Services (DHHS) to provide greater coordination at the federal level in collecting and disseminating data regarding patient mortality and morbidity so that Congress and the Administration can properly assess the impact of prospective payment has had on patients.

ASIM has informally distributed a survey to its members in an effort to gain a better understanding of the negative and positive aspects of the DRG system (Attachment 1). Although this survey is not scientific, it has revealed several troubling problems about the prospective payment system. Most bothersome is the fact that over 200 of the 246 respondents listed specific instances where they believed the quality of care of patients had been harmed by DRGs. The most common concern of members is that physicians are under considerable pressure to make either premature or inappropriate discharges. Another common concern mentioned by nearly half of the respondents was that DRGs do not reflect severity of a patient's illness. As one physician put it, "patients often have several diseases which need evaluation and/or treatment but DRGs relate to only one diagnosis, that means either poor care or cost overruns."

Further, the ASIM survey indicated that while the PROs have been established to monitor the patient care provided under Medicare, the PROs in too many cases have been primarily concerned with restricting hospital utilization rather than with ensuring quality of care. Approximately one quarter of the respondents believe that the PROs had increased the denial rates of medically indicated admissions under DRGs, to the detriment of patient care.

The Society believes this is partially due to the overemphasis on utilization review in the Health Care Financing Administration's Scope of Work for the PRO program. The Society has a long history supporting peer review of patient care that even predates the Medicare program. One of the Society's policies that has evolved from the experiences of internist-members states that "high quality medical care deserves precedence over considerations of cost in any peer review program." The Society is concerned that this has not been the case under the PRO program. Although technically HCFA requires PROs to meet certain quality objectives, the overriding emphasis of the program remains on limiting hospital utilization. The Society recognizes the importance of review to reduce unnecessary utilization, and supports such objectives, but we strongly believe that quality review must be the primary purpose of a review program, especially under a prospective payment system. For this reason, the Society has on repeated occasions encouraged HCFA to increase the emphasis on quality under the PRO program.

The concerns of the Society also have been echoed by other agencies and organizations. The American Association of Retired Persons has received hundreds of letters from its membership detailing problems they have encountered under the prospective payment system. The General Accounting Office has also studied this issue and found that (1) patients are being prematurely or inappropriately discharged from hospitals, (2) beneficiaries are confused about their rights and privileges under the present Medicare system, and (3) there is a lack of appropriate post-hospital care for those patients who are discharged from the acute care setting. Findings such as these and others by the OTA, Senate Special Committee on Aging and the U. S. Inspector General have provided further evidence that measures need to be taken to protect the health of Medicare beneficiaries.

In addition, the present emphasis on cost containment under the Medicare program has created a difficult and sometimes unfair tension for physicians. On the one hand, through prospective payment and peer review, physicians are expected to limit hospital admissions, medical services and other aspects of health care to that which is strictly medically necessary. On the other hand, physicians are expected to (and should) continue to be the patients' advocate regarding health care. The problem lies in the fact that there often is not a clear medical consensus regarding appropriate health care protocols for treating patients. Therefore, physicians are faced with a choice of providing care they consider to be prudent, and running the risk of having that care retrospectively denied by the PRO, or making difficult determinations that certain services may not be medically essential, and then facing the risk that the care may be deemed of poor quality and, possibly, sanctionable.

Decisions in these gray areas are particularly difficult, given that the paramount concern of any physician is the well-being of his or her patients. As a physician, I am aware of instances where patients have not met the PRO criteria for continued hospital care. However, because those patients were not well enough to take care of themselves, did not have an adequate family support system to care for them, or did not have necessary nursing care available, it was not medically adviseable to discharge them. In such instances, physicians and their patients are faced with a losing proposition. The physician can either release the patient against his or her best medical judgement or advise the patient to remain in the hospital, knowing that the patient may not have the money to pay for their continued hospital care if it is denied by the PRO--care that can cost as much as $800 a day. Both situations are detrimental to patients' physical and mental well-being.

This difficult situation is exacerbated for some physicians who practice at hospitals that keep track of admitting physicians' average case expenses. This can be to the detriment of patients' health care if attending physicians are experiencing direct or indirect pressure from the hospital to keep their hospital expenses in line with other physicians or under a certain cost level. If physicians fear that they will lose their admitting privileges because their cost averages are not in line with other physicians, then they understandably will feel strong pressure to curtail services so that they can continue to care for patients needing hospitalization. On the other hand, if pressure is applied to physicians to limit medical care that is more costly than that provided by other physicians, then the patient can also suffer if his or her physician concludes that the freedom to use services that are necessary is limited. Problems such as these make it essential that Congress enact legislation that allows physicians to provide health care that meets their best medical judgement and yet is cost efficient--and that places the proper emphasis on quality under the PRO program.

## The Medicare Quality Protection Act

ASIM commends Congressman Stark and Senator Heinz for sponsoring the Medicare Quality Protection Act to address many of the concerns described above. The Society supports this legislation because it will make necessary changes to protect beneficiaries under the DRG system. Specifically, this legislation will:

- enhance the quality of care in the hospital settings;
- provide for better care of patients once they are discharged from the hospital, and;
- enable PROs to better monitor the care by practitioners and providers to ensure that they meet their legal and professional responsibilities.

The Society takes this opportunity to comment further on specific provisions of the Heinz-Stark legislation:

1. Revise the Prospective Payment System to account for case complexity and severity of illness. ASIM believes the DRG system does not adequately account for different levels of resource consumption that are required for complex or serious illnesses. Each patient's illness is unique to that individual in that it varies in degrees of severity and complexity, depending on a number of factors such as age, general health condition, socioeconomic status, etc. Because each patient's illness is unique, a single diagnosis-related group cannot properly account for every patient's medical needs. In instances where a patient has a complex or serious illness, the hospital may be under extreme pressure to provide the minimum services required in order to limit potential financial losses. Allowances for complexity and severity should help correct this.

2. Inform patients of their appeal rights/Eliminate patient liability for hospital costs during a discharge appeal/Expedite appeals determinations. ASIM supports these provisions. The Society believes patients should be advised of their rights under the Medicare program when they enter a hospital. This permits a patient to be better informed of the PRO process before the health care is provided. It also allows patients to be better prepared to appeal discharge notices or PRO determinations should they occur. Information such as this will help ensure that beneficiaries receive proper care.

   Patients should also not be financially penalized if they file a discharge appeal. Under current provisions, patients have a disincentive to file an appeal of a discharge because they may be held responsible for some of the hospital care provided during the appeal consideration. The Society does not believe that such concerns should be allowed to influence a patient's decision if he or she feels that further medical care is necessary.

   The Heinz-Stark proposal further addresses this problem by requiring the PROs to reach a determination on an appeal within three calendar days. The purpose of this is to limit the liability of the hospital and the patient for the care provided during the discharge appeal. While the Society believes this is reasonable and appropriate, it also strongly emphasizes that it is essential that Congress appropriate sufficient additional funds to the PRO program in order to cover the increased costs in providing quicker appeal determinations. Too frequently in the past, after signing their contract, the PROs have had additional requirements placed on them without additional funds to compensate for those services. The Society believes that increased requirements such as this will only serve to undercut the effectiveness of the PRO program if PROs are forced to implement them without sufficient funds to assure that it is done properly.

3. Elimination of incentive plans that reward practitioners for meeting length-of-stay or per-case targets for individual patients. The Society supports this measure because it believes such plans provide perverse incentives under the prospective payment system to underprovide necessary services. ASIM believes that if such incentives are not eliminated, it could negatively affect the physician's traditional role as patient advocate.

4. Require the Secretary of DHHS to arrange for a study of hospital quality assurance standards for those facilities participating in Medicare. ASIM believes that a study should be conducted to see if the hospital quality assurance standards are still appropriate under PPS. The Society would further encourage that any findings from such a study be referred to the Joint Commission on Accreditation of Hospitals so that the medical community has input in the revision process.

5. Study the necessity and advisability of reimbursing hospitals for administratively necessary days (ANDs). In the DRG survey conducted by ASIM, one of the criticisms leveled by internists was that patients were transferred to inappropriate settings when they where no longer in need of hospital care. Victims of strokes and Alzheimer's disease are two of the types of patients that were mentioned by internists as being particularly susceptible to inappropriate transfers. They may no longer need hospital care but they do need other specialized care that is frequently not available. In such instances the Society believes that it is necessary to provide reimbursement to hospitals so that patients can be appropriately attended to until another appropriate post-acute facility is available. Therefore, ASIM supports a study on administratively necessary days.

6. Require hospital discharge planning that is approved by the attending physician. ASIM strongly supports this provision. This Society's internist-members consider this to be one of the major problems confronting Medicare. With DRGs, hospitals have incentives to discharge patients quickly, but not to provide all the necessary planning for a patient to be properly cared for after his or her discharge. Such a requirement would ensure that all beneficiaries receive thorough discharge planning so that their post-hospital care adequately meets their needs. The Society particularly emphasizes the importance of having the physician consulted in the development of the discharge plan so that all of the patients' medical needs can be accounted for before the discharge plan is actually implemented.

7. Continue the waiver of liability for skilled nursing homes and home health agencies. The Society has previously supported the continuation of the waiver of liability provision for skilled nursing facilities (SNFs) and home health agencies. It is difficult to predict whether Medicare will cover a given instance of care in a skilled nursing facility. Therefore, the waiver of liability protects these facilities when they admit a patient. The Society believes that if this provision is not implemented the health of beneficiaries will be jeopardized because SNFs will be reluctant to admit patients if it is not clear whether Medicare will provide coverage.

8. Require hospitals to submit data on a monthly basis for PRO review. The Society considers this to be an extremely important provision in the Medicare Quality Assurance Act. One of the ongoing frustrations with the PRO program for attending physicians, beneficiaries and PROs is that retrospective review often occurs too long after the fact to be fair or meaningful. This is largely because of the number of steps that occur between a patient's hospital care and the PRO's review. Presently, before a PRO can conduct a review, the hospital must file a claim for the care provided, the fiscal intermediary must refer the case for review to the PRO, the PRO must collect the records pertaining to the case, and then the PRO must discuss the case with the practitioner before it can reach a determination concerning the care. The proposal under the Heinz-Stark Act would expedite this review process and, consequently, enhance the value of PRO review.

9. Review hospital readmissions for selected DRGs that occur within 30 days of a discharge. The Society supports this provision as a means of ensuring that patients are not being prematurely discharged. Although the Society supports this provision, we must emphasize that should such a requirement be mandated, additional funding will be needed from Congress so that PROs can properly carry out the additional review functions. ASIM also supports the part of this provision that requires this review for only a few selected DRGs. This will allow PROs to focus on problem areas without spending a large portion of their time reviewing all readmissions occurring within 30 days.

10. Expand peer review outside hospital doors. In an effort to address quality issues outside of the hospital setting, the Medicare Quality Assurance Act would expand peer review to non-acute care settings, such as HMOs and ambulatory surgical centers. Medicare should address quality issues in these settings. However, if peer review is to be conducted on outpatient care, then the Society believes that such review should be limited to only those physicians or facilities identified as potentially aberrant through professionally developed utilization guidelines. This would allow PROs to address quality issues without becoming unnecessarily intrusive to the various practice settings.

11. Require PROs to have a consumer representative on their boards of directors. The Society views this as a worthwhile provision to help ensure that PROs remain sensitive to the concerns of beneficiaries. A beneficiary representative on the PRO boards would provide the PROs with helpful input in determining policy or procedures when carrying out their peer review functions.

12. Require all PROs to investigate all written complaints of beneficiaries concerning the quality of care they receive. The Society supports the thrust of this provision but believes it needs to be clarified in order to be sufficiently sensitive to the professional reputations of health care practitioners or providers who have not provided poor quality care. First, the Society suggests that the bill be amended so that the PROs would only be required to conduct preliminary investigations of all written complaints. The purpose of this investigation would be to determine whether grounds exist to conclude that "gross and flagrant" violations or "failure in a substantial number of cases" (sanctionable violations under the PRO regulations) may have occurred.

If an incident does not have merit, then the beneficiary should be so informed. However, if a reasonable cause is established that a major quality problem exists, then a full investigation should be pursued by the PRO that includes due process rights for the practitioner--rights that should be specified in the bill. If, after those due process rights have been fulfilled, and a clear Medicare quality problem has been confirmed, then the PRO should take appropriate action, including inform the beneficiary of its findings.

13. Require each PRO to spend a reasonable portion of its activities conducting quality review. As mentioned earlier, the Society is concerned that the PROs are not required under the current scope of work to conduct enough review of quality issues. Because of this, the Society firmly supports this provision and would encourage the Congress to further define "a reasonable portion" to ensure that quality review is in excess of its current levels.

14. Require PROs to share with federally funded quality assurance officials and state protection and advocacy officials information concerning instances of "gross and flagrant" services or "failure in a substantial number of cases" to provide quality care. The Society believes that information regarding incompetent or improper conduct needs to be shared with proper authorities to help assure that only qualified and competent practitioners and providers are able to provide health care. The Society has, in the past, advocated more effective coordination of quality review findings to help ensure that beneficiaries are protected from incompetent providers or practitioners.

The provisions in the Heinz-Stark bill are an important step in helping to assure that quality concerns are made public and properly handled. However, the Society believes that the language in the bill should be further refined to help ensure that the quality concerns are properly handled. The Society believes that information shared with other quality assurance officials should be restricted to cases sanctioned because of "gross and flagrant" care or "failure in a substantial number of cases." The reason for this is because PROs are expected to identify potential quality problems and then investigate them to ascertain whether they are true quality problems. If information is shared with other quality assurance officials before the PRO has fully conducted its investigation, then the professional reputation of the practitioner is put into question without appropriate due process. ASIM believes that this would have two negative effects. First, it would taint the reputation of professionals without due

process. Second, it would be likely to discourage physician reviewers from identifying some quality issues if they were afraid that the information would be used by other quality assurance officials before it was fully investigated.

The Society also believes that the information that is shared with state quality assurance officials should be restricted to state licensing boards. The licensing boards are the designated state agencies for determining whether or not a provider or practitioner is competent to provide health care. In making such determinations, the licensing board utilizes a variety of due process procedures to fully determine the competence of the physician or provider in question. If the incompetence of the provider or practitioner is verified, then the state licensing board removes or limits that person or institution's license. In those instances where a case is found to be a result of bonafide incompetence, and the license is removed or restricted, then the citizens within the state are properly protected. This information then automatically becomes public knowledge. Therefore, the bill should direct the PROs to share the information with only those state entities that have the legal authority to restrict practice.

15. Require the Secretary of DHHS to study a variety of quality concerns under Medicare. Many of the issues slated for study under this provision of the act are issues that the Society believes need to be studied, as it was pointed out earlier. However, the Society believes that there is sufficient information at this time for the Department of Health and Human Services to begin to implement a more thorough quality assessment program. Specifically, HHS should appoint a task force (with representatives, for example, from HCFA, the Office of the Secretary, the Center for Disease Control, the National Center for Health Services Research, consumer groups, physicians, hospitals, etc.) to develop a plan of action to obtain, coordinate and report to Congress and the public all currently available appropriate information on the effect of PPS on the quality of patient care.

As is evident by this testimony, the Society is strongly supportive of the Medicare Quality Assurance Act. If the Subcommittee chooses to make some of the changes suggested by the Society, ASIM believes that beneficiaries will be protected even further under the Medicare Prospective Payment System. However, the Society also emphasizes that it believes it to be essential that adequate additional funds be appropriated to help finance the various provisions within this bill, particularly with respect to the PRO program. Many PROs have had difficulty meeting all the objectives in their contracts because of their limited finances. Their financial constraints have been exacerbated by the fact that in the last two years the Health Care Financing Administration has placed additional requirements on the PROs without adequately adjusting their finances to properly implement those requirements. Although the Society firmly supports peer review, and while ASIM strongly endorses many of the provisions within the Medicare Quality Assurance Act, the Society believes that if the PRO program is expanded to a point that is not financially viable, then the health care of the beneficiaries will not be properly protected, the performance of the of the practitioners and providers will not be properly assessed, and the viability of the peer review program will be put in serious jeopardy.

This concludes our statement in support of the Medicare Quality Assurance Act. I will be happy to entertain any questions you may have regarding my comments on this bill. Thank you.

/srl
G-IB-0374

Chairman STARK. Nurse Mary Long of the American Nurses' Association. Welcome to the committee and proceed, Ms. Long, to expand on or summarize your testimony in any way you are comfortable.

**STATEMENT OF MARY LONG, R.N., MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES' ASSOCIATION, ACCOMPANIED BY THOMAS NICKELS, MANAGER OF LEGISLATIVE ACTIVITIES**

Ms. LONG. Thank you very much. I am accompanied today by Thomas Nickels, who is responsible for the legislative activities of the American Nurses' Association.

I would just like to share with you a brief statement from the American Nurses' Association. I am very pleased to appear today on behalf of the more than 180,000 members to express our strong support for H.R. 4638, the Medicare Quality Assurance Act of 1986. We commend you for your leadership in addressing some serious problems currently facing the Medicare Program. We believe that this legislation represents a good first step in correcting some of the negative fallout that we have witnessed from the implementation of the prospective payment system.

Mr. Chairman, last fall we testified before the Senate Aging Committee and the House Budget Committee on our observations about the impact of PPS. We cited various studies which documented more frequent home health visits to patients with more complex health care problems. Patients were being discharged earlier from hospitals, and they were generally in poor health at this time. The phenomena of "sicker and quicker" became a reality for our members providing services in the community.

We suggested to these congressional committees several proposals concerning how to cope with this problem, and we are pleased to note that your legislation does address many of these suggestions. We would like to address at this time two proposals in this testimony.

One, the use of a severity of illness index, and the inclusion of discharge planning as a condition for participation for hospitals. We strongly support your proposal to refine the present system of classifying episodes of hospital care under the prospective payment system. It is recognized that many DRG's include a wide range of cases in terms of the resources required for the diagnosis and treatment of the patient.

This lack of homogeneity within the DRG's produces payment rates that can greatly over or underpay hospitals. One of the most significant variables in the treatment of hospital patients is the amount of nursing resources. Presently, these resources are distributed on an average basis across DRG's with no recognition of the variability of these resources according to the patient's condition, which is extremely important.

Thus DRG prices fail to reflect the actual nursing resources utilized and resultant gross inadequacies. This is important to the Medicare Program because the nursing expenses account for up to 35 percent of all direct patient care costs, and about 50 percent of a hospital's nonphysician personnel budget.

While we agree that the DRG refinement should approximate the costs of medically necessary care as articulated in your bill, we also believe that the system should better reflect the intensity of nursing services provided to patients within each DRG. We therefore recommend that your bill require HHS to include a more precise method of allocating nursing resources among DRG's, along with the approximation of the costs of the medically necessary services.

The bill also requires hospitals, as a condition of participation under Medicare, to provide a discharge planning process. The American Nurses' Association has long supported the need for timely and professional discharge planning for hospital inpatients. With the advent of the prospective payment system under Medicare, earlier discharges from hospitals and other payers adopting similar payment arrangements, the importance of the appropriate discharge planning has never been more critical, as we see it today in the nursing profession.

Discharge planning judgments are critically important to both the patient's safety and for the quality of the patient's life. Diagnoses have to be made more accurate, as we see it. If the capabilities of the patient or the situation are overestimated or underestimated, further problems certainly can arise. If they are underestimated, then there will be additional major problems and concerns.

The patient is subject to unwarranted financial expense. If no proper discharge planning is done, the patient's quality of life certainly can be adversely affected. The addition of discharge planning to the condition of participation, I think, and so does the American Nurses' Association feel, that it would greatly enhance the quality of care.

We are concerned with one piece, however. We are concerned that H.R. 4638 requires discharge planning evaluation or a discharge plan must be developed under the supervision of a registered professional nurse, social worker, or other appropriate qualified personnel. Discharge planning currently is being performed by nurses and social workers, and we do not understand the need to include, "other appropriately qualified personnel." We believe that discharge planning is so vitally important in light of the real concerns over patients being discharged "sicker and quicker" that it should be mandated to be performed by those who are qualified to do so.

We do not believe that it is in the best interests of the patient to mandate unidentified individuals to be responsible for one or more important tasks as a part of discharge plans.

The Medicare Quality Assurance Act is a good first step, we feel, towards coming to terms with the down side of PPS, and the American Nurses' Association certainly looks forward to working with you, Mr. Chairman, and members of your committee, as you move forth with this legislation. Thank you for giving us the opportunity to provide some testimony before your committee.

[The statement of Ms. Long follows:]

STATEMENT OF MARY LONG, R.N., MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES' ASSOCIATION

Mr. Chairman, I am Mary Long, a member of the Board of Directors of the American Nurses' Association (ANA). I am pleased to appear today on behalf of our 188,000 members to express our strong support for the Medicare Quality Assurance Act of 1986. We commend you and Senator Heinz for your leadership in addressing some serious problems currently facing the Medicare program. We believe this legislation represents a good first step in correcting some of the negative fallout we have witnessed from the implementation of the prospective payment system (PPS).

While PPS has resulted in more efficient use of health care resources, it has also resulted in patients being released from the hospital "quicker and sicker." Some patients are even being discharged directly from intensive care units, yet continue to require such complex medical equipment as respirators, suction machines, nasogastric tubes, urinary catheters and continuous oxygen. Hospital nurses and community health nurses must spend more time providing, to patients and their families, the necessary information and instructions that will enable them to maintain safe, competent care in the home.

Mr. Chairman, last year the ANA testified before both the Senate Aging Committee and the House Budget Committee's Health Task Force on the issue of quality of care. At that time, Mary Fisher, Director of Nursing for the Thomas Jefferson Health District in Charlottesville, Virginia, testified concerning a study she was conducting, funded by the Department of Health and Human Services. The impetus for this study came from reports by local public health nurses in the spring of 1984 of a shift in patterns of care from more routine care for diabetics and patients with indwelling catheters to more complex care, including indwelling arterial-venous catheters and intravenous antibotics. There was a need to document changes in referrals and patient needs in order to plan manpower and service responses. The study describes observed changes in home health nursing service referral patterns and associated nursing service changes.

The most significant finding from the study was that:

Home health care patients required significantly more frequent visitation and more intense and complex nursing services after the implementation of DRGs. Requests for daily visits rose from 11 percent pre-DRG to 22 percent post-DRG; requests for visits three times per week rose from 0 percent pre-DRG to 11 percent post-DRG. The intensity of nursing services also increased from a pre-DRG mean of 2.22 to a post-DRG mean of 2.83.

Home health care patients now require significantly more frequent visitation and more intense nursing services after the implementation of DRGs in the primary referral hospital.

Another recent study drew similar conclusions. A 1985 study of the Southwest Long Term Care Gerontology Center at the University of Texas Health Science Center at Dallas, in cooperation with the National Association of Area Agencies on Aging, reported the findings of a national survey of Area Agencies on Aging concerning changes in service demand and service delivery patterns under DRGs.

Major findings in the report indicate that after the implementation of PPS:

There was a major shift in service delivery patterns. Case management services increased 365 percent, in-home skilled nursing increased 196 percent, housekeeping services increased 69 percent, and personal care increased 63 percent.

The length of time and number of visits per client both increased. This trend is more dramatic among those agencies in areas where DRGs have been in effect the longest. Some agencies have been forced to cut number of service units per client in order to provide services for a longer period of time.

The greatest demand on agencies by hospitals was for coordination of multiple community services for older persons and their family caregivers, and for personal care services.

Inadequate family support was a major reason for readmission to hospitals. It is this one service area, however, for which a decrease in service units was documented.

Mr. Chairman, at that time the American Nurses' Association offered several recommendations to the Budget and Aging Committees for improvements in the current status of Medicare:

1. Peer Review Organizations (PROs) should be mandated to do more quality assurance monitoring and enforcement activities, especially as relates to inappropriate and premature discharges.

2. The DRG classification system should be changed to better reflect differences in severity of illness between patients in the same DRG category so that hospitals receive sufficient payment to provide adequate care.

3. Services such as counseling, health education and other health prevention services should be included as covered home health benefits.

4. The onset of PPS has placed such great demands on the community-based care systems, that the current level of community-based services available to Medicare beneficiaries is inadequate to handle their health needs. This fact should compel Congress to increase the community resources available to satisfy the increased need. Development and use of alternative health care delivery systems, such as free-standing nurse-managed centers, is one viable option.

5. Congress should request that a study be done on the impact that PPS has specifically had on community-based systems.

Mr. Chairman, in our view, your legislation has addressed a number of our recommendations in this area. In particular, your efforts on behalf of improved discharge planning, the use of a severity of illness index, and expanded responsibilities for peer review organizations should work to help remedy this critical problem. We would like to take this opportunity to address each of these issues.

### SEVERITY OF ILLNESS INDEX

Section 101 of the bilkl requires the Secretary of Health and Human Services to develop a legislative proposal to improve the prospective payment system to assure that the amount of payment approximates the cost of medically necessary care, and that the Secretary shall account for variations of severity of illness and case complexity which are not accounted for by the current system. It is clear that a consensur has developed that the current DRG payment system is in need of some serious refinement. While all the evidence is not in, it appears that hospitals are not being paid in a way that reflects actual resource utilization. Hospitals should not be underpaid or overpaid for particular services rendered.

The American Nurses' Association strongly supports efforts to refine the present system for classifying episodes of hospital care under the prospective payment system. It is widely recognized that many DRGs include a wide range of cases in terms of the resources required for the diagnosis and treatment of the patient. This lack of homogeneity within DRGs produces payment rates that can greatly over or under pay hospitals.

One of the most significant variables in the treatment of hospital patients is the amount of nursing resources. Presently, these resources are distributed on an average basis across DRGs with no recognition of the variability of these resources according to the patient's condition. Thus DRG prices fail to reflect the actual nursing resources utilized and result in gross inequities in the payment to hospitals. Several studies suggest that there is a wide variability in the amount and intensity of nursing care received by patients with the same diagnosis. This is important to the Medicare program because nursing expenses account for up to 35 percent of all direct patient care costs, and about 50 percent of a hospital's non-physician personnel budget. While we agree that the DRG refinement should approximate the cost of medically necessary care, as articulated in your bill, we also believe the system should better reflect the intensity of nursing services provided to patients within each DRG. Hospital nursing care is a significant component of overall health activities and costs, and the utilization of nursing care varies by type of patient. Any patient classification system or severity of illness measure used to determine payment must reflect the utilization of nursing services.

The ANA recommends that your bill require the Department of Health and Human Services (HHS) to implement a more precise method of allocating nursing resources among DRGs. Such an allocation procedure woul be intended to allocate nursing costs on the basis of the actual nursing resources required for the condition of the patients within each of the DRGs rather than on the basis of the patient's length of stay. Such a provision would be consistent with your intention to adjust DRGs to take better account of the severity of illness of Medicare patients.

### RECOMMENDATION

On page three, line ten, insert after "medically necessary care" the phrase, "and nursing care."

DISCHARGE PLANNING

Section 201 of the bill requires hospitals, as a condition of participation under Medicare, to provide a discharge planning process. The ANA has long supported the need for the timely and professional discharge planning for hospital inpatients. With the advent of prospective payment system under Medicare, earlier discharges from hospitals, and other payers adopting similar payment arrangements, the importance of discharge planning has never been more critical.

Discharge planning judgments are critically important for both the patient's safety and for the quality of the patient's life. Diagnoses have to be made accurately. If the capabilities of the patient or situation are overestimated, further problems can arise; if they are underestimated, the patient is subjected to unwarranted financial expense. If no proper discharge planning is done, the patient's quality of life may be adversely affected. The addition of discharge planning to the conditions of participation will greatly relieve this potential pitfall.

We strongly support the requirement in your draft bill that participating hospitals must provide discharge planning services. While most institutions may have such a program on paper, we suspect that gaps exist, and that implementation is not uniform across hospitals. Further, we believe an acceptable discharge planning process must be built around a core group of registered nurses or social workers. These are the professionals with the best education and experience to supervise discharge planning activities.

We are concerned, however, that Section (ee)(2)(G) states that any discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. Discharge planning is currently performed by nurses or social workers, and we do not understand the need to include "other appropriately qualified personnel." This term is not defined in the law, and would be left to the discretion of the Secretary. We believe that discharge planning is so vitally important in light of the real concerns over patients being discharged "sicker and quicker" that it should be specifically mandated to be performed by those best educated to do so. We are concerned about quality discharge planning, and do not frankly know who could adequately perform these tasks other than a nurse or social worker. We do not believe that it is in the best interests of the patient to mandate unidentified individuals to be responsible for one of the most important tasks being performed in hospitals.

RECOMMENDATION

On page 14, line 3, after the words "social worker" place a period, and strike everything thereafter.

PEER REVIEW ORGANIZATION

The ANA has identified the peer review process as the essential component in quality assurance programs. We have supported the PRO program and worked to encourage the participation of our members in it. Nurses perform the initial screening of Medicare cases and provide critical liaison to the institution subject to review.

Patients are being discharged sooner and in more acute stages illness, resulting in increased use of skilled nursing facilities, home health services and community services. The quality and level of care availability to beneficiaries in these alternative settings are critical to the patients' outcomes of illness for which they are originally hospitalized. We support the recommendations of ProPAC that "the focus of PRO quality of care review should be on the entire episode of care", including the post-acute of skilled nursing home health care.

We would like to state an additional concern. In 1983, Congress amended Section 1154(a)(5) of the Social Security Act to state that PROs shall consult with nurses and other professional health care practitioners with respect to the PRO's responsibility for the review of the professional activities of such practitioners. Regrettably, regulations published in 1984 ignored Congressional intent that peers should review peers. While Section 446.102(c) of the regulations provides that a denial determination of services provided by a health care practitioner other than physician must be made only after consultation with a peer of that practitioner, it then states that final denial determinations must be made by a physician. Nowhere in the original statute was it stated that a final payment determination of respecting the quality of the services of a registered nurse should be made by a physician; rather, it is quite clear than peers should review the activities of peers. Since your proposed legislation deals with issues such as the composition of PRO boards and improved review

of quality of PROs, we believe that it would be appropriate to clarify the original intent of Congress that peers should review peers.

RECOMMENDATION

On page 29, after line 14, add a new Section 306 to the bill: Section 306. Peer Review Activities by Practitioners Other Than Physicians.

(a) Section 1154(a)(5) of the Social Security Act (42 U.S.C. 1320c-3) is amended at the end by adding, "Nurses and other health care practitioners shall also be responsible for final denial determinations of the services of their peers."

CONCLUSION

All available evidence indicates that the implementation of PPS has caused some serious repercussions in the manner in which health care is being administered. While increased economic incentives have had a positive impact on controlling industry inflation, it has raised real fear among beneficiaries that their care will be more affected by market forces than by medical necessity. Registered nurses, as patient advocates and providers of care, are seeing the impact of PPS daily and are concerned that any negative fallout be addressed by the Congress in a timely manner.

The Medicare Quality Assurance Act of 1986 is a good first step toward coming to terms with the "down side" of PPS. Provisions dealing with a severity of illness index, discharge planning, and expansion of PRO responsibilities to include services provided outside the inpatient setting will address some serious deficiencies in the system. We again commend the Chairman for his work in this area. We intend to work actively for quick passage of this bill, and ask that the Committee give serious consideration to our additional recommendations, which we believe would add to an already positive piece of legislation.

Chairman STARK. Thank you very much, Ms. Long, and I thank the panel. I would like the panel to remain for a few moments. I am delighted to recognize the coauthor of H.R. 4638, Senator John Heinz. I would like to recognize him at this point for any comments he would like to make. Welcome to the committee.

## STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA, AND CHAIRMAN, SPECIAL COMMITTEE ON AGING

Senator HEINZ. Mr. Chairman, thank you. It is nice to be back at your committee. You have graced me with the opportunity of testifying here on other occasions. You have invited me to sit in with your very expert panels of witnesses.

I want to apologize to everybody. I meant to be here at 10 o'clock this morning when Chairman Stark meant to convene the hearing, but a number of us were invited down to the White House for a friendly session of arm twisting on the Canadian free trade zone. I only got out of the subbasement, away from the branding irons, recently.

I want to express my particular appreciation, though, to Pete Stark for championing the issues that are in the legislation before us, and for his coauthorship of the Medicare Quality Protection Act. Over here it is H.R. 4638, on the House side it is Stark-Heinz, on the Senate side it is Heinz-Stark, and only the twain will meet in conference.

I think it is worth noting that we have remarkably broad sponsorship on this legislation. I don't know if Pete mentioned it but Bill Gradison and eight other members of the Ways and Means Committee are original cosponsors of the bill. On the Senate side, original cosponsors include Senator Dave Durenberger, chairman

of the Health Subcommittee, and five other members of the Health Subcommittee.

We are all deeply indebted to the endorsement of the legislation by the American Association of Retired Persons, the American Society of Internal Medicine, the American Nurses' Association, the National Council of Senior Citizens, and the National Association for Home Care, a very wide, broad coalition of support.

Everyone should have, by now, a good working familiarity with the elements of the legislation. In the course of the hearings held on this issue by the Senate Special Committee on Aging, which I chair, we generated a tremendous amount of information on the effect of PPS on quality of care. I brought just off the press today, Mr. Chairman, your very own copy—I will be happy to autograph it—of our hearings before the Aging Committee last fall. During those hearings we had some absolutely incredible case examples. I will just give you two of them.

First, an 85-year-old woman was discharged from a hospital to a substandard nursing home, against her doctor's recommendation, mind you, and against her family's wishes, following a 12-day stay in a hospital for two heart attacks and a stroke. She died within 24 hours of the discharge. She died in a substandard nursing home. She died after being discharged against her doctor's recommendation.

The second case involves a 75-year-old woman. She was in a car accident. The car was totaled. She was denied admission to the hospital, even though her head had been badly hurt in the accident. She was sent home by the hospital with the hospital knowledging that she might have suffered a concussion, and with instructions that she should wake herself up every 4 hours to make sure she hadn't suffered a concussion, even though she lived alone.

Well, I am not saying that is standard medical practice and standard hospital practice. Frankly, I believe most doctors and most hospitals are extremely conscientious and would never permit anything like this to happen. But the fact that these cases and others are happening and are linked to the new change in Medicare hospital payment should give us cause for concern. Clearly, this kind of behavior is unacceptable and we should take no part in underwriting it. Congressman Stark and I intend to do something about it. And, of course, that is what the Medicare Quality Protection Act is all about.

Mr. Chairman, the historical development of this issue really began with the American Medical Association, when in December of 1984 it published an informal survey of its members. You have to remember prospective payment was only enacted in 1983 as part of the Social Security Amendments. In 1984, a large majority of the AMA's membership responded by saying that quality of care had already deteriorated under PPS or would deteriorate under PPS, and they indicated that they as doctors were already feeling pressure in some instances from hospital administrators to violate their own medical judgments in treating patients, that there were patients being discharged for a primary condition and being readmitted for a second, that patients were being released prematurely, and that they were taking a more critical look at tests and procedures they ordered.

And then the General Accounting Office, in February 1985, followed that up with their own report. They concluded that patients were being discharged sicker and quicker than before PPS, and in too many cases and—this is the key point—being discharged into inappropriate levels of care or no care at all, which I have called the no care zone.

The committee's hearings are a matter of historical record. Our investigation began in February 1985. Our hearings were conducted on September 26, October 24, and November 12, 1985. We found what I think has been presented here, that there is some pressuring of doctors by hospitals, that patients and their families often receive false or incomplete information about their appeal rights; that PRO's have only a very limited snapshot picture of what is happening to the patient, and no picture at all of postacute care, and too often that the patients are discharged into an inappropriate postacute setting for followup care. And now, the inspector general of the Department of Health and Human Services, Richard Kusserow, found substantial evidence of those inappropriate transfers and premature discharges in a new study recently released.

This bill, I believe, represents the most significant, most concrete solution to the problems identified through the Senate Aging Committee's investigations as well as those findings of the inspector general, the Society of Internal Medicine, and many other sources.

I would respectfully ask, Mr. Chairman, that the committee consider three additional initiatives that are not part of the bill, as you and I introduced it, and I respectfully submit and ask for your consideration of them. Whatever you decide to do is fine with me, because you and I are together on the underlying bill.

My suggestions are as follows: First, although the PRO's, which were created to ensure quality control, not just cost control in the Medicare system, were given statutory authority needed to enforce quality care, the Health Care Financing Administration has never issued instructions and guidance to PRO's in using that authority. The PRO's need the ability to carry out their statutory authority.

I would love to see both our Senate bill and H.R. 4368 modified to give the Secretary the mandate to issue those guidelines within 6 months of enactment. If the deadline were not met, the Secretary would have 6 months to approve or disapprove proposed guidelines submitted to the Secretary by the PRO's.

A second item, Mr. Chairman, would be the following. We do recognize that some hospitals are in a crunch. In a number of States—I don't know if California is one of them, but I think you are getting there—there are shortages of nursing home beds and appropriate home health care. When a hospital can't place a patient because the needed posthospital care isn't available, they often can claim with justification it is not their fault for keeping the patient. I think this argues strongly for making it easier for hospitals to get administratively necessary days.

Those administratively necessary days are payments to hospitals to keep those patients until appropriate care can be found for them outside of the hospital. Because of the way the payments are made, most hospitals do not make these additional days available to patients. What I am suggesting is that the payments should be separated from the current DRG payment, in which they are now

lumped, and they should be paid out of a separate fund to ensure that these patients aren't lost into that no-care zone.

Mr. Chairman, this is part of my personal view that we are saving a lot of money under DRG's, under prospective payment. That is good. We needed to. The Medicare Program was much too fat, making a lot of people much too happy, on the provider side.

If we are saving a lot of money on the acute-care side by discharging people, in effect, sicker and quicker, we have got to recognize there is a cost to that. We should be willing to plow back into the system a modest amount of those savings, to accommodate those additional demands on care. Otherwise, we just invite massive cost shifting.

My last suggestion, Mr. Chairman, would be to include the Medicare Program under the APA—the Administrative Procedures Act. Currently, Medicare is exempt from notice and comment provisions under the APA. While the Department of Health and Human Services currently follows the APA requirements for regulations on a voluntary basis, I believe we need to make that voluntary agreement a legal requirement to ensure that Medicare beneficiaries and providers continue to receive that important information. The idea here is the people who would be affected by the proposed changes need appropriate advance notice in order to comment on the proposals and fine tune those changes and regulations.

I believe that, in addition, HHS–HCFA transmittals, guidelines and instructions to the fiscal intermediaries should also be subject to public notice under the APA, and I suggest that we require published notice in the Federal Register of the issuance of those Medicare guidelines.

The argument against this proposal is that it will create too much additional paper in the Federal Register. Well, last year the Federal Register published approximately 112,000 pages. This requirement that I have just suggested would add about 70 pages a year to the Federal Register. I don't think that is an overwhelming burden. None of us welcome paperwork. This is just notification. It just gets information out. It is not placing a burden on anybody.

Those, Mr. Chairman, would be my suggestions. I just want to say in conclusion that it has been a pleasure working with you these last several months on this legislation. I look forward to working very closely with you in moving it ahead. It is very important that we keep in mind that while it takes us a good part of the way toward ensuring that patients continue to receive the very best health care possible under Medicare, even more needs to be done than I have discussed here. There are substantial problems of quality of care that still exist in the long-term and posthospital side of the health care system.

The second part of my answer to ensuring the quality of care for Medicare and Medicaid recipients is that I will soon introduce an additional bill that will propose solutions to two kinds of very serious problems that exist in those settings. But that is another story for another day, Mr. Chairman, and I appreciate your courtesy in inviting me here to make some comments and to sit in with you as you listen to these witnesses.

[The statement of Senator Heinz follows:]

(P.34

STATEMENT OF SENATOR JOHN HEINZ

BEFORE THE HOUSE WAYS AND MEANS COMMITTEE, HEALTH SUBCOMMITTEE

THE MEDICARE QUALITY PROTECTION ACT OF 1986
April 23, 1986

Mr. Chairman, I am very pleased to have the opportunity to submit testimony to the Health Subcommittee as it considers H.R. 4638 and S. 2331, the Medicare Quality Protection Act of 1986. Congressman Stark and I introduced these identical bills on April 17, along with 8 original cosponsors from the Ways and Means Committee, including Mr. Gradison, and 5 members of the Senate Finance Committee, including the distinguished Health Subcommittee Chair.

Introduction of this bill was greeted with support from a wide range of senior advocate and provider groups, including the American Association of Retired Persons, the American Society of Internal Medicine, the American Nurses Association, the National Council of Senior Citizens, and the National Association of Home Care.

I am very pleased that the Ways and Means Health Subcommittee is holding a hearing on this bill so soon after introduction. The Senate Special Committee on Aging has held four hearings on the issue of quality of care under Medicare's prospective payment system, conducted an intensive year and a half long investigation, and held extensive meetings with many of the groups affected by the Medicare prospective payment system.

I'd like to share with you two cases, representative of the hundreds of quality of care problems brought to light during this investigation. In the first, an 85 year old woman was discharged from a hospital to a substandard nursing home against her doctor's orders and against her family's wishes following a 12 day stay in a hospital for 2 heart attacks and a stroke. She died within a day of being discharged. Two days later, the family received a letter informing them of their rights to appeal the discharge. The second case involves a 75 year old woman who was in a car accident in which her car was totalled. She was denied admission to the hospital and sent home with instructions that she should wake herself every four hours to make sure she hadn't suffered a concussion, even though she lived alone. The fact that these cases, and other like them, happen under our federal health care system is simply unacceptable.

I am confident that the Medicare Quality Protection Act, which was developed as a result of this investigation, provides doable, real world solutions to the very serious problems we identified.

The purpose of the Medicare Quality Protection Act is to improve quality in hospital and post-hospital settings and ensure greater access to post-hospital services. The bill does not seek to dismantle PPS; nor does it impose a new layer of red tape and burdensome regulation on providers. On the contrary, it darns holes

and repairs flaws in existing Medicare and Medicaid laws, strengthening quality and access to care while continuing to provide for effective Medicare cost containment.

In 1983, Congress acted to save a financially strapped Medicare program with the Prospective Payment System. We had confidence that this new reimbursement method could halt spiralling hospital costs and restore solvency. The good news is that our confidence has been rewarded. Hospital costs in 1985 increased by only 6 percent--the lowest rate of increase in the past 20 years.

But Congress also recognized that PPS contained certain inherent incentives to cut back on the level and quality of care provided patients. So Congress charged the Peer Review Organizations with the responsibility of monitoring quality and sanctioning providers who place high profits above good medical practice.

The bad news is that within a year of implementation, many physicians and consumers expressed concern that PPS did indeed pose a serious threat to quality of care for Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

In early December 1984, the American Medical Association published the results of an informal survey of its members. A large majority of those responding said quality of care had already deteriorated, or would deteriorate as a result of PPS. Hospital administrators were reportedly pressuring doctors to violate their own medical judgment in treating patients by: discharging patients for a primary condition and readmitting them for a second; releasing patients prematurely; and taking a more critical look at tests and procedures they ordered.

In February, 1985, the General Accounting Office released preliminary findings of a study it was conducting at my request on the impact of PPS on post-hospital care. Summarizing testimony from hospital, nursing home, and home health agency representatives from six communities around the nation, the GAO concluded patients were being discharged from hospitals "sicker and quicker" than before PPS and, in too many cases, they were being discharged to inappropriate levels of care or no care at all. These findings were echoed in a joint hearing of the House Select Committee on Aging and the Task Force on Rural Elderly on February 26, 1985.

From the beginning, the Administration, through the Health Care Financing Administration, chose to deny any deep flaws in the DRG system. I quote from HCFA Administrator Carolyne Davis' own testimony before Congress that "while there have been isolated instances of premature discharge and inappropriate transfer, there has been no evidence of systemic abuse." HCFA argued that the watchdogs of quality, the PROs, were doing their jobs and that no major problems were developing.

As the agency with administrative and rule-making responsibility for Medicare, HCFA is vital to the success or failure of the PRO program, the collection of data on quality and access under PPS and the overall operation of prospective reimbursement. But despite well documented evidence of program abuse, HCFA repreatedly referred to "anecdotal episodes" and failed to make necessary reforms.

In February, 1985, the Senate Special Committee on Aging launched its own investigation into quality of care under PPS. Committee staff visited and collected data from five peer review organizations, and several community and university hospitals. The inquiry involved scores of interviews with Medicare beneficiaries, practicing physicians and nurses, university researchers, personnel from the Health Care Financing Administration, and the Department of Health and Human Services Office of Inspector General. In addition, Committee staff gathered and analyzed volumes of records obtained from these organizations and individuals.

The Committee's investigation led to three hearings in the fall of 1985: September 26, October 24, and November 12. The Committee looked at quality of care issues in hospital and post-hospital settings and heard witnesses from 14 states detail a large variety of problems with quality and access. We also heard from a wide-ranging set of experts on ways to respond to the various problems developing under PPS.

The Committee found that quality of care problems are widespread. Our most disturbing evidence showed:

- o Hospitals are pressuring doctors to keep ill people out of the hospital and to discharge others in an unstable condition;
- o Patients and their families often receive false and incomplete information regarding their rights under the new payment system;
- o PROs have only a snapshot picture of quality and feel hamstrung by a "restrictive, underfunded, inflexible and narrowly-focused" review program; and
- o Too often, patients are discharged to an inappropriate setting for follow-up care.

The Aging Committee's findings have since been reinforced by the Inspector General of the Department of Health and Human Services. In a new study of premature discharges and inappropriate transfers, Inspector General Richard Kusserow found substantial evidence of premature discharges and inappropriate transfers. He also found that the PROs had not been effectively using their enforcement powers to address instances of poor quality care. During the period reviewed, October 1, 1983 through May 5, 1985, 14 of the PROs studied were not reporting premature discharges or inappropriate transfers. The IG concluded that, "therefore, the over-all extent of the problem is still not fully known." Quality issues ranged from minor to gross and flagrant violations. Further, Mr. Kusserow placed blame for this problem on the doorstep of HCFA for failing to give clear and

consistent guidance to the PROs as to their quality assurance responsibilities.

The Medicare Quality Protection Act provides a very significant step forward in solving these serious quality of care problems. It makes needed adjustments in Medicare's hospital prospective payment system and the peer review process to improve quality of care in acute and post-acute facilities. It also improves Medicare patients' access to needed post-hospital care, protects and expands patients' rights in hospitals, and improves coordination among those federal agencies responsible for the health care of our nation's elderly.

This bill, I believe, represents the most significant and most concrete solutions to the problems identified through the Senate Aging Committee's investigation, as well as the findings of the Inspector General, the American Society of Internal Medicine, and many other important sources. At the same time, this bill underwent many revisions as we tried to accomodate the differing interpretations and concerns that were raised. In line with our mutual goal of ensuring Medicare beneficiaries the highest possible level of health care, the Committee may wish to consider a few suggestions as to how we might bring the bill even closer to meeting that goal completely.

First, the Peer Review Organizations were created to ensure quality of care under Medicare's prospective payment system. Although the PROs were given the statutory authority needed to enforce quality of care, HCFA has never issued instructions and guidance to PROs in using this authority. As a result, very few denials have been instituted even in cases of severe quality of care problems. We need to change this. I believe H.R. 4368 should be modified to give the Secretary of HHS six months after date of enactment to issue these guidelines. If this deadline is not met, the Secretary would have six months to approve or disapprove proposed guidelines submitted to the Secretary by the PROs.

PROs should also be given explicit authority to deny payments in cases where providers have failed to provide necessary medical services to Medicare patients. This explicit statutory authority will help the PROs deal with physician incentive schemes that would encourage physicians to provide fewer services or authorize fewer hospital days than are medically necessary for care of the individual patient. It will also help PROs act with authority as they review the quality of care in health maintenance organizations.

Third, hospitals need to be given the flexibility to keep patients in their facilities who no longer need hospital care, but for whom needed post-hospital care just is not available. These patients, for example, are ready to leave the hospital but need skilled nursing or home health care that is not available, perhaps because the skilled nursing facilities in that area have no empty beds available or because their is no one at home to care for the Medicare patient. Administratively necessary days, payments to hospitals to keep these patients until appropriate care can be found

for them outside the hospital, are currently provided for in the statute. Because of the way the payment is made, however, most hospitals do not make these additional days available to patients. These payments should be separated from the current DRG payment and paid out of a separate fund to ensure that these patients are not lost into the no care zone.

Under our bill, Mr. Chairman, discharge planning and physician sign-off on a discharge plan are necessary for hospitals to meet the conditions of participation in the Medicare and Medicaid programs. But the problem still exists that if the care the patient needs out of the hospital and the discharge planner recommends just is not available, that patient will still be discharged, most likely to home. Shortages of skilled nursing beds and inadequate home health situations abound in this country. We need full implementation of ANDs, in a budget neutral basis, if possible, to fill in the gap until a bed can be found, or the home situation stabilized.

Further, I would advocate that no changes be allowed to weaken the current hospital conditions of participation until after the study called for in our bill is complete. At that time, with a full review of current conditions and suggestions for improvement in hand, we can better judge proposed changes to these important criteria. Any changes in the meantime, I believe, would bring us at best to a scatter-shot approach to quality of care.

One last suggestion I would make, Mr. Chairman, includes bringing the Medicare program under the Administrative Procedures Act. Currently, Medicare and Medicaid regulations are exempt from notice and comment provisions under the APA. While HHS currently follows APA requirements for regulations on a voluntary basis, we need to make this voluntary agreement a legal requirement to ensure that Medicare beneficiaries and providers continue to receive this important information.

In addition, I believe HHS/HCFA transmittals, guidelines and program instructions to fiscal intermediaries should also be subject to public notice under the APA. I suggest that we require published notice in the Federal Register of the issuance of these Medicare and Medicaid guidelines, including the name and phone number of the HCFA contact responsible for the issuance -- not publication of the full text. HCFA often uses these guidelines and trasmittals to institute important changes in Medicare policy, such as its interpretation of "intermittent" care. Currently, information about Part B changes can only be found in a private, costly journal, unavailable to many providers and senior advocates. Last year, the Federal Register published 112,000 pages. This requirement would add an estimated 70 additional pages a year -- not an overwhelming burden on the federal government, and certainly a small price to pay for informed beneficiaries and an openly run federal health care program.

The quality abuses documented under the DRG system cannot be halted without a comprehensive strategy for reform. We in the Congress have but one priority in this effort: to restore public

confidence in the system and assure quality health care. The Medicare Quality Protection Act is designed with this priority in mind.

The Congressional Budget Office has estimated that our bill will cost a mere $200 million over the next three years. This is a small price to pay to ensure quality of care, especially when we consider that, over that same time period we're likely to spend more than $200 billion on the Medicare program as a whole. The prospective payment system, which is a prtial cause of quality problems, is saving the Medicare program between $3 billion and $4 billion every year. Thus, spending less than $70 million a year is a worthwhile investment for protecting the quality of care under that system.

A summary of the major findings of the Senate Special Committee on Aging and the key provisions of the Medicare Quality Protection Act follow in the rest of my written statement that I ask be included in the record. I also request that copies of the staff reports from the three hearings the Senate Special Committee on Aging held last fall on this issue be included in the hearing record.

Mr. Chairman, it has been a pleasure working with you in developing this legislation. It's very important that we keep in mind, as we discuss this legislation, that while it takes us a good part of the way towards ensuring that patients continue to receive the very best health care possible under the Medicare program, much more still needs to be done. Substantial problems in quality of care still exist in the long term and post-hospital side of the health care system. As the second part of my answer to ensuring quality of care for Medicare and Medicaid recipients, I will soon introduce a bill that will propose solutions to the very serious quality of care problems that exist in those settings. I hope I can count on your support, and the support of the many distinguished colleague on both sides of the Hill who cosponsored the Heinz-Stark Medicare Quality Protection Act, in ensuring that quality of care exists in the full circle of federal health care programs.

I look forward to our continued efforts toward bringing the Medicare Quality Protection Act to passage and I thank you for convening this hearing.

## I. PROTECTING QUALITY IN ACUTE CARE SETTINGS

(1) Refining the DRGs: Under PPS, patients deemed "DRG losers" by doctors and hospitals--patients with multiple serious conditions--are being prematurely discharged, inappropriately transferred, or refused admission for care. The problem is that DRGs reimburse based on average cost for a principle diagnosis, with no flexibility in payment to account for so-called differences in "severity of illness" among patients with the same diagnosis. Such an inequitable standard for payment encourages treatment of the straightforward case and the younger patient over treatment of the heavy care and older patient.

The Heinz-Stark bill requires HHS by January 1, 1988, to develop a PPS patient classification system that reflects variations in severity of illness and case complexity among patients within each diagnosis related group (DRG). HHS would also be required to consider possible changes in outlier policy as an alternative method of accounting for variations in severity and complexity.

2. Inadequate Rights of Appeal: The Aging Committee's investigation revealed that many patients who may wish to present evidence of substandard care or challenge a hospital discharge decision are unaware of their right of appeal, or are given false or incomplete information regarding this right. ProPAC also identified this as a problem in its 1986 Report to HHS and Congress.

At a hearing last fall of the Committee, one witness spoke of the anguish of having to watch her 85-year-old mother be discharged to a substandard nursing home against the doctor's orders and the family's wishes after a 12-day stay in the hospital for two heart attacks and a stroke. Carol Mahla's mother died within a day of being transferred. Two days later, the family received a letter informing them of their rights to appeal the discharge.

Mrs. Mahla's story is not unique. Under pressure from the Senate Aging Committee and consumer organizations, HHS recently improved patient notification procedures by requiring hospitals to provide notice of rights upon admission. But this notice stops short of ensuring that patients will be informed of their rights in a way that is clear and understandable. Current regulations, moreover, give hospitalized patients 48 hours to appeal a discharge before they can be held legally liable for any additional billings. Yet the PROs have three working days to respond to the appeal. This leaves the beneficiary at financial risk of having to pay out-of-pocket for one or more days of hospital care while awaiting a decision from the PRO.

The Medicare Quality Protection Act both improves patient notification and reduces the risk of accumulating out-of-pocket costs for hospital care while awaiting a decision from the PRO. First, HCFA would be required to grant beneficiaries 3 calendar days for appeal after receiving written notification of discharge before they begin to incur liability for a continued stay. Second, PROs would be required to decide appeals of continued stay denials within the same timeframe--3 calendar days.

Finally, in cases where the hospital serves a written notice ofdischarge but does not express intent to bill for a continued stay, the patient will be granted this same right to appeal. This extension of the appeal right plugs a loophole in the law which often results in the hospital telling patients to leave without informing them they can appeal the discharge decision.

3. Prohibit Incentives or "Kickbacks" that Potentially Lead to Reduced Care. At seven hospitals operated by the Paracelsus Health Care Corporation of Pasadena, California, doctors receive bonuses if

costs are kept within DRG range. Similiar programs elsewhere in the country also provide a one-to-one compensation of the physician for discharging a patient early. By creating a direct monetary incentive to reduce care, this new form of kickback threatens the well-being of Medicare patients. Current Medicare fraud and abuse law does not address this problem.

The Heinz-Stark bill specifically prohibits physician incentive plans that involve a payment for meeting specific per-case length-of-stay or cost targets. Violators of this provision would be subject to a civil monetary penalty. Additionally, the bill requires HHS to develop legislative recommendations by July 1, 1987 to prohibit or regulate other plans that have the effect of pressuring physicians to discharge patients prematurely or to reduce medically appropriate services.

4. Preserving Existing Quality Protections: The Aging Committee's investigation revealed substantial shortcomings in the existing quality assurance standards under both the Joint Commission for Accreditation of Hospitals and the Medicare Conditions of Participation. Yet even these limited protections face dilution by HHS' proposed revisions of the hospital "Conditions of Participation."

This bill requires that within two years of its enactment, HHS must submit to Congress a study concerning the adequacy of existing quality assurance standards for participating hospitals, including but not limited to consideration of the effect of changes in reimbursement policy since 1982. This provision would send a strong signal to HHS to hold off any regulations that might significantly weaken quality assurance requirements, while the Department examines ways to improve these requirements in the future.

## II. IMPROVING ACCESS TO POST-HOSPITAL CARE

DRGs drive patients out of hospitals quicker and sicker. This finding is not dangerous in and of itself, since days-of-stay often exceeded what was medically necessary under the old system. But sicker and quicker can be hazardous when combined with the fact that post-hospital services are strained by the burden of more patients needing greater levels of care. For some Medicare beneficiaries, post-hospital care is unavailable or substandard.

The fact that the stress on post-hospital services is substantially increasing was confirmed by the General Accounting Office and by dozens of post-hospital care providers interviewed by the Senate Aging Committee's staff. These witnesses testified that more and sicker patients are being released into the community, often to the care of families who are not prepared or able to adequately care for them. One 65-year-old woman, a bilateral amputee with renal failure, with a colostomy, was sent home to an apartment with no running water, to the care of an unreliable 19-year-old grandchild. A 79-year-old woman hospitalized for a complete hip relacement,

unable to walk or feed herself, was sent home alone where she was found several days later by a family member.

The Committee also learned that given the shorter length of stay and reduced staff in many hospitals, patients often are too sick to respond positively to educational efforts and nurses are too shorthanded to spend the extra time needed to train the patient or family for home care.

Shortages in home health and nursing home care are aggravated by widespread illegal discrimination against Medicare and Medicaid eligible patients, witnesses told the Committee. Nursing homes prefer the more profitable private-pay patients and those for whom care is less costly.

HCFA has denied that demand for home health and skilled nursing care has significantly increased under PPS. Nevertheless, the Aging Committee's investigation confirmed with data from HCFA internal reports a nearly 40% increase in discharges to skilled-nursing and home health care since October 1983.

Options for community services narrow further when quality becomes part of the supply equation. HCFA cites more than 970 nursing homes as chronically substandard. Mrs. Mahla's mother was forced into such a home, where she died after 14 hours. For too many it is a choice of no bed, or a substandard one.

Access to home health and skilled nursing care is also restricted through the administration of the Medicare home health and SNF benefit. William Dombi, attorney from Legal Assistance for Medicare Patients in Connecticut, testified at the Committee's October, 1985 hearing that HCFA has "circumvented the law and subverted the intent of Congress....through oral and written policy directives, all designed to curtail home health and skilled nursing facility coverage." Mr. Dombi went further to assert that "there are two Medicare programs, the one that is on the books under 42 USC Section 1395 [and the one based upon the] directives of the Health Care Financing Administration." Other witnesses from the long-term care provider community confirmed that "patients cannot be admitted for care because of restrictive HCFA guidelines".

All of these factors contribute to reduced access to post-hospital care for Medicare patients. While some of these problems existed prior to the implementation of PPS, they clearly are magnified by the increased numbers of sicker patients being discharged from our Nation's hospitals. The Medicare Quality Protection Act addresses this problem in the following ways:

1. Require Discharge Planning: Under current law, only hospitals that voluntarily choose to have a Department of Social Work are required to meet Federal rules for discharge planning (and these rules have been criticized as inadequate by health care professionals). HCFA plans to do away with even these lax rules. Existing hospital discharge planning programs--important mechanisms

for assuring that patients are placed in appropriate community settings-- are seriously overtaxed under PPS, with the result that Medicare patients often receive inadequate post-hospital care.

Take the case of Mrs. S, a 71-year-old woman who was sent home after a six-day hospitalization. She is legally blind, wears a pacemaker, is a diabetic, and has had a stroke and kidney failure. A home health nurse was not called by the discharge planner for four days. When the nurse arrived, she found the patient alone, with no food, taking the wrong medication dosage. This kind of tragedy should not happen.

The Medicare Quality Protection Act would make discharge planning a condition of participation for hospitals in the Medicare program,and for those hospitals deemed "certified" as a result of JCAH accreditation. Hospitals would also be required to have an effective discharge planning process. The bill spells out procedures to be followed when discharging a patient that were recommended by the American Association for Continuity of Care. Upon request of the patient, the attending physician, or someone acting on the patient's behalf, the hospital would be required to provide an initial discharge planning evaluation. Implementation of a final discharge plan would require approval of the attending physician.

2. Require HHS to study the need for Administratively Necessary Days: Many communities have a severe shortage of skilled nursing beds. Hospital patients in need of skilled nursing care in such a community are placed in a life threatening state of limbo. The hospital that keeps the patient ends up either absorbing the cost for the patient's sub-acute days of stay (Medicare covers only acute days of hospital care) or attempting to recover the loss from the patient. Alternatively, the hospital will send the patient home, with or without the necessary medical and social support services. Too often the latter scenario prevails. And as Medicare continues to ratchet down DRG payments to hospitals, making losses on sub-acute patients even less attractive, the number of elderly being discharged to inappropriate settings will rise.

Prior to PPS, Medicare paid for sub-acute care at a reduced rate until the patient could be transferred to a skilled nursing facility. These were referred to as payments for "administratively necessary days." Given the circumstances outlined above, it may be necessary to reinstate these payments. Under the Heinz-Stark bill, HHS is required to conduct a study to determine whether a separate payment should again be made to a hospital for "administratively necessary days," or days of care provided for skilled nursing patients who cannot be promptly discharged to skilled nursing care. The Secretary is required to report back to Congress not later than January 1, 1988.

3. Eliminate Unpredictable Retrospective Denials of Payment for Post-Hospital Care.

Currently, there is a great deal of ambiguity and uncertainty about what Medicare covers for home health or skilled nursing care. This uncertainty is the result of unclear guidelines and vague definitions by HCFA and wide variations in decisions by the fiscal intermediaries (FIs) regarding payment for services needed.

Since the FI makes the coverage decision after services have begun, providers can be left without payment for care already delivered. If a potential patient's coverage under Medicare is in doubt, the facility may decide against providing that patient with services.

The Medicare waiver of liability was designed to give limited financial protection to health care providers who accept patients they have good reason to believe are eligible for coverage, but whose claims are denied after care has begun.

Obviously, elimination of this waiver might discourage health care providers from participating in the Medicare home health and skilled nursing program. But just last year, HCFA proposed that Congress do just that. Strong opposition by Members of Congress, providers, and beneficiaries resulted in Senate language in the Reconciliation Bill to extend the waivers. These provisions were agreed to by both Houses in conference on the Consolidated Omnibus Budget Reconciliation Act, and are now part of P.L. 99-272.

The Medicare Quality Protection Act would make permanent the waiver of liability for SNFs and HHAs. In addition, the waiver of liability would be extended to include denials made because it was determined that the patient failed to meet the homebound or intermittency requirements for home health coverage under Medicare. The bill also provides for an expedited retrospective review process, ensuring that the waiver will continue until the review determination is made by the fiscal intermediary. Finally, the bill enables providers to appeal denials of home health and SNF coverage on behalf of beneficiaries.

4. HHS to develop a Uniform Needs Assessment Instrument:

Currently, there is no basis for judging how effectively health care services meet the needs of long term care patients or of ensuring that long term care patients are given the appropriate types or levels of care. A needs assessment tool can help providers to: 1) objectively and consistently evaluate the health care needs of long term care patients and 2) match those needs with appropriate available long term care services. In this way, we can ensure that long term care patients have access to needed health care services and that the long term care system can be wisely developed based on actual patient needs.

The Medicare Quality Protection Act requires HHS to develop, within one year of enactment, a uniform needs assessment instrument that evaluates: 1) the functional capacity of an individual; 2) the nursing and other care requirements of the individual to meet health

care needs and to assist with functional incapacities; and 3) the social and familial resources available to the individual to meet those requirements. This instrument shall be developed for the use of discharge planners, hospital and post-hospital providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care, home health, and other long-term care services.

## III. IMPROVING PRO QUALITY ASSURANCE

HCFA has focused the PROs on a very narrow and incomplete set of quality issues; therefore HCFA's assessment of quality of care is grossly deficient. When the Aging Committee began its investigation in February, 1985, the quality assurance activities of the PROs were extremely limited. Hampered by HCFA's inconsistent and often unreasonable instructions, the PROs were only identifying the tip of the iceberg of quality problems developing under PPS. I am pleased to report that progress has been made in improving the ability of the PROs to monitor quality of care, and to exclude unfit providers and hospitals from delivering care to Medicare beneficiaries. But there are miles to go before the PROs are able to fully and effectively carry out their mandate as the watchdogs of quality under the Medicare program.

Under the new round of PRO contracts, now being negotiated with HCFA, the PROs' scope of review for premature discharges will be limited to those cases where the patient is readmitted to a hospital within fifteen days, and to those instances of possible substandard care that can be detected from using generic quality screens. This means that cases of readmission after fifteen days or to hospitals outside the PRO area, deaths after premature or inappropriate discharge, denials of admission, inappropriate placement out of the hospital and lack of adequate care in the community will still not be reviewed by a PRO.

Thomas Dehn, M.D., President of the American Medical Peer Review Association, testified to the Aging Committee that HCFA primarily wants data from the PROs on utilization of stay—i.e., number of admissions, costs per admission etc.—and is less concerned with quality review. AMPRA's report, "PROs: The Future Agenda", dated September 1985 and prepared by their Task Force on PRO Implementation, states that "The present quality assurance system required under PRO contracts is limited, restrictive, and lacks the innovation needed at a time when the incentives of PPS raise the potential for compromised care. The imposition of quality objectives presupposes baseline data that can validate the existence of quality problems. Given the advent of prospective payment, no such data is available across a wide spectrum of in-patient care to the elderly. Only now are quality care concerns surfacing."

The PROs would thus like to broaden their quality review activities, and to review on a sample basis, quality problems beyond the hospital door. They can only do this, however, if they are given adequate funding and consistent guidelines from HCFA. In reviewing

PRO performance, HCFA should give at least equal weight to quality assurance activities as is given to utilization review. In addition, HCFA must establish workable data transfers from the hospital to the PROs that will facilitate timely and efficient quality review.

The Aging Committee also heard from Medicare beneficiaries that PROs often are slow or completely fail to respond to their complaints about quality problems. Nor is there a mechanism to provide for beneficiary participation in decisions affecting PRO activity.

The Medicare Quality Protection Act takes a number of steps to address these problems:

1. Expand PRO Review of Quality of Care Under the Heinz-Stark bill, PROs will be required to review selected samples of readmissions to hospitals within 30 days. They will also be required to review quality of care in selected home health, nursing, board and care homes, and outpatient hospital settings where they have identified potential quality problems. Finally, the bill requires hospitals to submit monthly data to enable PROs to perform reviews on a timely basis.

2. Allocate PRO Funds to Ensure Increased Quality Care Review: The Medicare Quality Protection Act requires that each PRO provide that a reasonable proportion of its activities are involved with reviewing the quality of services provided in cases and settings for which potential problems of quality have been identified.

3. Improve PRO Accountability to Medicare Beneficiaries: The Heinz-Stark bill would require each PRO to appoint a consumer representative to its board. In addition, PROs would be required to investigate all written complaints about quality of care filed by a beneficiary (or a person acting on behalf of a beneficiary). HHS would develop appropriate procedures for investigating and responding to these complaints. These procedures would provide protection of the confidentiality of the complainant and provide that the PRO's report their findings to the complainant.

## IV. IMPROVING DATA ON QUALITY OF CARE UNDER PPS

According to the GAO, HHS lacks any statistically valid basis to confirm or deny the effect of DRGs on the quality of health care older Americans need or receive upon discharge from the hospital. According to GAO testimony, HHS does not have the necessary data to evaluate whether PPS has either increased or decreased the quality, access, demand, use or cost of post-hospital care for Medicare beneficiaries. Furthermore, HHS is not planning to do the types of evaluations that are necessary to determine whether PPS is the cause of changes in these five areas.

1. HHS to Develop a Long-Term Quality Assurance and Review Strategy: The Heinz-Stark bill requires HHS to provide for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under Medicare. In developing this

study, HHS shall consult with consumer groups, PROs, the Joint Commission on Accreditation of Hospitals, professional societies and private purchasers of health care with experience and expertise in monitoring the quality of care.

2. Extend HHS reporting requirements on quality in post-hospital settings. HHS is currently required to report on an annual basis on the impact of PPS. For these reports to be useful, they need to cover PPS effects on both hospital and post-hospital care. Under the Quality Assurance Act, HHS would be required to provide three annual impact reports providing (1) an evaluation of quality assessment and assurance in the "continuum of care;" (2) an assessment of access problems of special beneficiary populations; and (3) data on Part A and Part B beneficiary appeals.

3. Sharing of Confidential Information Regarding Quality of Care:

There is a woeful lack of information exchanged about problem health care facilities. Thus, hospital discharge planners are sometimes unaware that they are sending a patient to a substandard nursing home. Under the Medicare Quality Protection Act, instances of gross and flagrant patient neglect as well as patterns of poor quality care, could be shared with selected federally-funded quality assurance officials, provided that adequate assurance of confidentiality can be provided.

[The staff reports referred to have been retained in the committee files. "Impact of Medicare's Prospective Payment System on the Quality of Care Received by Medicare Beneficiaries." "Medicare DRGs: The Government's Role in Ensuring Quality." Special Committee on Aging. U.S. Senate.]

Chairman STARK. Senator, you honor us by your presence and your considerable expertise and prestige in this area, I am sure, will hasten the day when we can see our legislation signed into law. I happen to agree with particularly the first two additions that you had suggested, and initially had planned to include them in the bill.

One of our cosponsors had felt that these two issues might raise some objections, and had asked that they be deleted as part of his agreeing to cosponsor. I have the feeling that we may be able to get agreement among our cosponsors to add those.

As to the availability of these additional days, as I understand your suggestion, where there is no other place, that the hospital could keep the patient and not have it changed against the DRG. Would it be your feeling that where the hospitals have less than full occupancy, that these would be at some reduced costs?

Senator HEINZ. Yes.

Chairman STARK. The marginal cost to the hospital would be added and there would be another function?

Senator HEINZ. Yes, that is correct, and specifically what I would propose, Mr. Chairman. They would not be anything like what has now become the new Medicare part A deductible going up to $572 a day if we don't do something about it, or the $490 and some odd dollars that it jumped to this last December. The answer is it would be an effective cost.

Chairman STARK. In relation to your first suggestion by way of introducing Dr. William Moncrief, who just testified as president of California Medical Review, Inc., which is our PRO in California, I would ask the doctor if in fact what Senator Heinz referred to in terms of the guidance and enforcement is similar to the concerns you raised about our having to direct you legislatively to proceed.

Dr. MONCRIEF. Mr. Chairman and Senator Heinz, this has been a worry in the physician community, coming up with quality standards or quality guidelines, particularly in California, in the environment in which we practice. There is a lot of reluctance to see published standards of quality. At the present time—and this is what makes quality review so expensive—we depend on practicing physicians to make a judgment, "Is this quality of care acceptable to the physician's community in which the care is being delivered?" And in the instances in which that answer is no, why, we proceed with sanctions.

Chairman STARK. If I understand, the Senator's first change was that we have guidance on enforcement, once you have determined that there is——

Dr. MONCRIEF. We have some pretty clear guidelines in the sanction process: 85-6, the PRO 85-6 clearly spells out the sanction process, once we identify a gross and flagrant or in a substantial number of substantial cases.

Senator HEINZ. You may be more aggressive than PRO's generally. We had a number of PRO individuals plus the national chairman of the group representing the PRO's who, as I recollect, is from Michigan——

Dr. MONCRIEF. Wisconsin.

Senator HEINZ. I knew it was up there around the Great Lakes someplace. And they indicated that they felt that guidance or en-

couragement was as a general rule necessary to PRO's in general to take enforcement actions. They seemed to feel that they were getting ambivalent signals from HCFA, and that it would be helpful as a general rule. Now you may, since clearly the intent of Congress was to authorize you to take the necessary actions—and that is in the statute, there is no denying that, that you may have actually been guilty of reading what Congress said, and interpreted what we intended. This makes you, by the way, a prince among men, and it may be that not everybody is up to your advanced high quality standard of practice.

Dr. MONCRIEF. I think there is a tendency in the PRO community to occasionally waffle on quality issues.

Senator HEINZ. Yes.

Dr. MONCRIEF. But I think with Mr. Kusserow's needling and also with Mr. Nathanson's increased emphasis, his office's emphasis in this area, that nearly all PRO's are proceeding along the lines in which Congress intended.

Chairman STARK. I would like to address for a moment, if the Senator would yield, a question to Ms. Long.

If I understood your testimony, you felt that discharge planning should be performed only by either a trained nurse or a social worker; is that correct?

Ms. LONG. What we would like to have is some clarification of who those other entities may be.

Chairman STARK. I want to see if I understand. Discharge planning, it seems to me, need not necessarily involve the patients save for understanding perhaps the patient's circumstance. You have to know something about the patient other than what the illness is. Do they live alone, what kind of provisions are there? But discharge planning, as I see it, is distinct from informing the patient of their rights. They are two separate sorts of issues, are they not?

Ms. LONG. Well, professionally, I think it is a part of, but for 25 years having worked in a large city hospital, a part of my responsibility was to look at discharge planning and make sure that people were appropriately placed in different setting, and I certainly feel that she must have really a knowledge base of what is available by way of community resources, availability of followup care, and also as well, information about the individual rights.

Chairman STARK. But doesn't the patient generally have, at least in my limited experience, some contact with a steely-eyed person who suspects that he is a bad credit risk and is not as ill as they portray who is sitting across the desk from him asking him all kinds of useless questions—that is the admissions person.

They certainly don't behave like social workers, and they are a lot crueler and harsher than any nurses that I have ever come across. So I suspect that it is at that time that the patient might like some warmth and acceptance and maybe some information on what rights he has.

Ms. LONG. As we see it, discharge planning is certainly more than that. There are those "individuals."

Chairman STARK. Isn't that the time the patient should be advised of his rights, though, by whomever is signing him up in effect?

Ms. LONG. Certainly, I think that is a part of it. But it is even more than that. It is the whole survival piece once I am discharged, how I will survive in the community, and I think you have to have knowledgeable people to tell me.

Chairman STARK. I hear what you are saying, but I just wanted to make that separation, advising somebody in effect of their rights. I asked Dr. Moncrief and Dr. Tingley, and perhaps Nurse Long, I guess, it is my suspicion that on the average, people want to get out of the hospital. I mean, it would be the rare person who says, "Gee, I really like it here. The food is better than it is at home. The television works better. They have got Home Box Office and Showtime."

Senator HEINZ. You have good hospitals in California.

Chairman STARK. Aren't the instincts to say: I want to get out of a hospital, generally speaking? Is that an assumption that we can use in planning here, Dr. Tingley?

Dr. TINGLEY. I think that is generally true. However, there are a lot of qualifiers to that. There are people who are better off in the hospital than they are at home. There are people who really enjoy the fine attention that our good nurses give them in the hospital setting, and perhaps would like to enjoy it a little longer than they are really required to.

I think as a planning guideline most people certainly would prefer to be in their homes. Unfortunately, the biggest problem that we have as physicians is when we come up to the magic day that we feel that they could do as well in another setting, and the patient says, "But I am awfully weak, Doctor." And we realize the patient is going to be awfully weak for some time, and that the hospital is not the answer to that. It really is a significant problem, so I don't want to understate that part of it either.

Chairman STARK. Dr. Moncrief.

Dr. MONCRIEF. I think across the board people would prefer to be treated on an outpatient basis, the elderly particularly, and with the elderly, why, hospitals are sometimes bad for them. I think that, or I know that a hospital cannot discharge a patient without a doctor's order.

I know Senator Heinz brought up the point of the lady discharged against the doctor's orders. I have to emphasize that patient care in a hospital setting is an institutional responsibility, hospital admission and medical staff, and a hospital cannot discharge a patient unless the attending physician writes that order, or the chief of medical staff. A doctor has to write the order. These sorts of things worry me as a practicing physician, and I am sure Dr. Tingley has the same feeling too.

We have a responsibility to this patient to see that they get the appropriate care. But a lot of these issues we are talking about are benefit issues. The Medicare law is written, and I am sure I would be much more willing and would encourage, if Congress would authorize, an expanded Medicare benefit issue to include hospital reimbursement or acute care reimbursement for what now is not considered inappropriate acute hospital reimbursement. A lot of these problems are benefit issues.

I can endorse Ms. Long's comments that the majority of nurses working on the floors are aware of discharge planning, and I think

in the majority of instances it is the bedside nurse who initially approaches the discharge planner and says, "Mrs. Smith is going to be going home in a couple of days and Dr. Jones really hasn't requested discharge planning. Why don't you get to working on this." I think most nurses on the floor do work with that in mind, because they are acutely aware of the problem.

To answer Senator Heinz' question about California, I don't think we have a shortage of postacute hospital resources, if you want to pay for them. The problem is that the Medicare reimbursement is not sufficient, and the constraints on Medicare reimbursement for a postacute hospital care are so constrained that it is just not available to a lot of these people.

Senator HEINZ. Mr. Chairman, could I interrupt here?

Chairman STARK. Please, Senator.

Senator HEINZ. I now have another engagement; I am suffering from compression of the Senate schedule today. I would just request unanimous consent that my entire statement be made a part of the record at the appropriate point.

Chairman STARK. Without objection, and as you and your staff have a chance to review the prepared testimony, I would like to invite you to submit written questions to these witnesses and previous witnesses who have all indicated a willingness to respond to them, and we would make both your questions and the answers a part of the record.

Senator HEINZ. Thank you, Mr. Chairman.

Chairman STARK. I appreciate your being here and look forward to your working with us.

Mr. OWEN. Mr. Chairman, could I ask Senator Heinz a question? On the second proposal concerning administrative necessary days, I think you are absolutely on track on that one. I would take it that you are not talking about a budget neutral position, however?

Senator HEINZ. No, I don't see any way that that in all fairness could be made budget neutral.

Mr. OWEN. Otherwise we are destroying——

Senator HEINZ. I think a reasonable suggestion for the rate of reimbursement would be—people disagree with it—would be at the skilled nursing facility rate for hospitals, which is a far cry lower than $494.

Chairman STARK. I would feel somewhat better about that if we had Jim Miller as a cosponsor on this bill.

Senator HEINZ. This may be difficult but we shouldn't give up.

Chairman STARK. Again, thank you. We have a vote. We have about 20 minutes remaining. It will be my intention for those of you with heavy lids or growling stomachs to try and work through and hear the next panel. I want to thank this panel for their willingness to cooperate. I want to ask one question, Dr. Moncrief. Perhaps he could quantify later for the record. It might be difficult.

I am curious first of all in terms of the adequacy of the funding. I was also convinced that my mother was lying to me when she said "Enough is enough." I have concluded since I have taken over this subcommittee, that she may have been right. But in any event, the question has been raised, are we adequately funding the PRO's? I think you indicated that, no, the cost of quality review is far higher than compliance review.

Could you give us, at some point, some ideas of the next step, and that is what would be a reasonable increase? Would ProPAC be a reasonable group to review the funding that the PRO's get, and what kind of a major increase in your costs do you see this bill, if it were properly administered by PRO's.

In your opinion what is the magnitude? Would you have to increase your funding by 20, 30, 50 percent? As I say, I am not sure you are prepared for that. But it would certainly be of some interest. We will come up against it as we proceed.

Dr. MONCRIEF. I will ask that of Andy Webber, executive director of the American Peer Review Medical Association, because the PRO's are in the midst of negotiations for the second round of contracts. I think we can put together a reasonable consensus on what it will cost, because certainly the second round of contract emphasizes quality versus the initial round on utilization. What will this bill add, I don't know. We just don't have the data on which to base anything like that.

I think that if—and this is underlined several times—that if HCFA would let those PRO's who feel it appropriate and can rearrange their review and do skilled nursing facility review, we would get some idea on the magnitude of this problem. But at the present time our contracts are so proscriptive that we don't have that flexibility.

Chairman STARK. Let me ask you one other question while I have got you here. What is your feeeling as to the disagreement between those professionals who are used to being reimbursed on a fee for service and those who are more apt to be on some kind of participation or salary plan.

It occurs to me that the easiest solution to that is to expand the PROs to include physicians or people operating in the HMO's along with those operating on the fee for service and let the PRO cover both sides of the issue. Can one group review both HMO's and fee for service hospitals. Would you care to comment on that?

Dr. MONCRIEF. I would be glad to. Of course we take the position, the PRO's take the position, that quality is quality whether it is delivered in the closed panel or open panel environment or whatever it might be. Quality is quality, and that we, the PRO's, should be doing review. I understand in the HMO community there is a lot of concern about access to physician records, office records, outpatient records and this sort of thing.

I think the answer to that would be I don't think the PRO's want random access to physician office records or outpatient recoreds, but just those that would support or confirm a quality issue as it might be identified under the PRO review program.

We in California have 18 physicians on the board; 11 are associated with HMO's of one kind or another, and so we feel certainly in California that there is not this great difference. I understand in other parts of the country, why, they are not quite so magnanimous in getting along with each other.

Chairman STARK. Does anybody else have a comment?

Thank you. I want to thank the panel. Thank you very much. I appreciate your taking the time and effort to enlighten us today.

As is the tradition here of saving the best for last, our final panel will consist of Alan Spielman, executive director of government re-

lations for the Blue Cross and Blue Shield Association, accompanied by Norma Border, Office of Medicare Policy; Ms. Agnes McBroom, president of the American Association for Continuity of Care; Ms. Margaret J. Cushman, chairman of the Government Affairs Committee for the National Association for Home Care; and Dr. Paul Willging, executive vice president of the American Health Care Association.

Normally other Members would be here. I am going to ask you to start summarizing or expanding on your testimony in the order in which you appear. At some yet to be determined moment, I will have to dash for a vote, and if you would at that point just hold everything, and I should be able to get over and back in slightly under 10 minutes. We will just have a short break if that vote occurs as I suspect it will in the next few minutes.

Mr. Spielman, would you like to proceed.

**STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR FOR GOVERNMENT RELATIONS, BLUE CROSS & BLUE SHIELD ASSOCIATION, ACCOMPANIED BY NORMA BORDER, DIRECTOR, OFFICE OF MEDICINE POLICY**

Mr. SPIELMAN. Thank you, Mr. Chairman. In the interest of time I will be very brief, confining my remarks on the bill to those provisions dealing with posthospital care.

The Blue Cross & Blue Shield Association strongly supports the requirement for discharge planning in hospitals. Discharge planning is an effective component of our managed care programs, where plans work with hospital discharge planners.

The bill also extends the waiver of liability process for home health services to the homebound and intermittent care requirements. We support this effort in order to improve the predictability of coverage decisions in this area for beneficiaries and providers. Judgment must necessarily enter into the decisions on the particular requirements.

The bill also would require HHS to develop an expedited review process for posthospital claims, and again we support that, because of its improvement in predictability. However, we would caution that for such a requirement to be effective, adequate funding needs to be allocated to enable intermediaries to perform reviews in a prompt manner. In fact, as mentioned at yesterday's hearing on Medicare contracting, current HFCA policy runs in the opposite direction.

HCFA has directed contractors to increase overall claims backlogs in an effort to save administrative and program funds. We would, therefore, strongly urge that this provision be coordinated with the appropriations process, and that funds be earmarked to improve the review process for posthosptial claims.

In this area, we also would like to recommend two other proposals. First, we would urge demonstrations under Medicare of certain private sector approaches to the review of the appropriateness and cost effectiveness of services. In particular, we recommend demonstrations to test a prior approval process for the review of post-hospital care.

In our private business, the preadmission review of hospital services is an extremely important component of our managed care programs, and we believe that experience could be effectively applied to Medicare. We believe that an effectively run prior approval process may be a more appropriate long-term solution to the problem of retroactive denials than continuing indefinitely the waiver of liability mechanism.

We would also suggest a demonstration of individual benefits management, under which an intermediary would consult with providers, physicians and patients to develop and approve payment for otherwise noncovered Medicare services where medically indicated and appropriate and where the substitution would not increase program costs.

Second, we would urge greater attention to beneficiary and provider education. This could reduce the need to pursue appeals and help reduce the number of claims filed improperly. This, however, also relates back to the funding issue. Adequate funding needs to be provided.

Finally, in response to some of the earlier discussion, we would urge that efforts to expand PRO quality review to other provider settings not disturb the Medicare coverage and utilization review determination process that intermediaries are now performing effectively, and I might add, highly efficiently.

Thank you, Mr. Chairman. This concludes my remarks.

Chairman STARK. Thank you very much.

[The statement of Mr. Spielman follows:]

**TESTIMONY**

**OF THE**

**BLUE CROSS AND BLUE SHIELD ASSOCIATION**

**ALAN P. SPIELMAN**

**EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS**

Mr. Chairman and Members of the Subcommittee, I am Alan P. Spielman, Executive Director for Government Relations of the Blue Cross and Blue Shield Association, the national coordinating organization for all the Blue Cross and Blue Shield Plans. Today our Plans underwrite or administer health care coverage for 100 million Americans, including more than 20 million Medicare beneficiaries. Under contracts with the Health Care Financing Administration, our Association and member Plans serve as Medicare intermediaries and carriers responsible for most of the day-to-day administration of this important program.

We appreciate this opportunity to comment on H.R. 4638, the Medicare Quality Assurance Act of 1988, introduced by Representative Fortney H. (Pete) Stark (D-CA) and Rep. Bill Gradison (R-OH), and other Members of Congress. H.R. 4638 is intended to respond to a number of concerns that have arisen with respect to the possible effects of Medicare reimbursement policy on quality of care. In particular, the bill would:

- Require HHS to develop a method for accounting for variations in severity of illness and case complexity in the PPS system, revise the notification and appeal procedures for beneficiaries, and prohibit certain hospital-physician incentive plans.

- Improve access to appropriate post-hospital care by requiring all hospitals to engage in discharge planning, making permanent the waiver of liability for skilled nursing facilities (SNF's) and home health agencies (HHA's), extending the waiver of liability for home health services to "technical" coverage issues such as the homebound and intermittent care requirements, directing that HHS develop an expedited review process for SNF and HHA claims, requiring a 24-hour response on beneficiary eligibility for post-hospital SNF care, and allowing providers to bring appeals on behalf of beneficiaries and to appeal "technical" denials.

- Improve review of quality of care by PROs by directing the review of early readmission cases and making other changes in the PRO program.

- Require a major two-year study that would assist in the development of a long-term strategy for quality assurance.

**Quality Assurance in Hospital Settings**

We strongly support the development of refinements to the Medicare prospective payment system to increase the accuracy, equity, and effectiveness of the system. Such refinements would provide reasonable assurance that the "winners" and "losers" under the constrained payment system reflect true differences in efficiency and not simply the result of imbalances in the system.

In particular, we support the development and implementation of a measure of severity of illness for the PPS system. We also support efforts to improve current procedures to assure that beneficiaries receive adequate notice and have adequate appeal rights with respect to the denial of benefits for inpatient hospital care.

**Access to Appropriate Post-Hospital Care**

We strongly support requiring that hospitals engage in discharge planning as a condition of participation in Medicare. Indeed, in the private sector working with hospital discharge planners is a growing component of the managed care programs that an increasing number of Blue Cross and Blue Shield Plans are administering for employers. Effective discharge planning can assure that patients receive adequate care after discharge as well as encourage the most cost effective delivery of such care. We recommend, however, that the required discharge planning functions be defined and implemented flexibly to minimize the burden on small and/or rural hospitals.

The bill includes a provision to broaden the "presumed waiver of liability" mechanism that home health agencies use to help mitigate the effects of unanticipated retroactive denials. That mechanism currently applies only to claims denials based on medical necessity and custodial care coverage requirements. The new provision would extend the presumed waiver of liability mechanism to the requirements that, in order for the services to be covered, the patient need skilled nursing care or certain therapies and the patient be homebound.

This provision is primarily a result of concern that these coverage requirements — the homebound and intermittent care requirements — have been implemented inconsistently across the country by fiscal intermediaries and that some intermediaries have applied them more rigorously than intended by the law. In our view, while the homebound and intermittent care requirements do result in some denials of care, these generally stem not from overzealous implementation of these requirements but the requirements themselves. As an intended response to the concerns that were raised, the Congress included a provision in the Deficit Reduction Act of 1984 that required HCFA to designate ten intermediaries, rather than the current number of 47, to handle home health claims. To help ease the transition for home health agencies during the move to new intermediaries, the Comprehensive Omnibus Budget Reconciliation Act of 1985 provided that home health agencies would continue to be eligible for presumptive waiver of liability status under current rules for 12 months following the implementation of the regionalization.

We believe that most home health agencies are sufficiently familiar with Medicare coverage requirements to minimize the need for waiver of liability type mechanisms with respect to any coverage requirement in present law. However, we do recognize that elements of judgment necessarily enter into the claims determination process and that the directive to reduce the number of intermediaries will make it even more difficult for intermediaries to take into account the unique local circumstances surrounding a claim for home health coverage. We are, therefore, supportive of the extension of the waiver of liability to the homebound and intermittent care requirements to the extent that it will improve the predictability to providers of intermediary coverage decisions. We would note, however, that this provision is likely to increase Medicare benefit expenditures for non-covered care.

As mentioned previously, the bill would also require HHS to develop an expedited review process for claims submitted by skilled nursing facilities and home health agencies. Again, we would support such a requirement because it would help improve the predictability of the claims determination process. However, we would caution that for such a requirement to be effective adequate funding needs to be allocated to enable intermediaries to perform reviews in a prompt manner. In fact, current HCFA policy runs in the opposite direction. As we indicated yesterday before this Subcommittee in our testimony concerning Medicare contracting, HCFA has directed contractors to increase overall claims backlogs in an effort to save administrative and program funds. We would, therefore, strongly urge that this legislation be coordinated with the appropriations process, and that funds be earmarked to improve the review process for post-hospital claims.

Regarding the provision to require a 24-hour response to inquiries concerning beneficiary entitlement to post-hospital SNF care, we would note that the recent HCFA decision to eliminate the Notice of Admission will make it more difficult for Medicare to make prompt determinations in this area. The Notice of Admission was submitted by hospitals and SNFs to Medicare intermediaries as beneficiaries were admitted to the facility. Upon receipt of this notice, intermediaries would query HCFA's eligibility system; HCFA responded on average within 48 hours with data on the beneficiary's Part A eligibility, available benefit days, and whether the deductible had been met.

We have not taken a position on the provision of the bill that would allow providers to bring appeals on behalf of beneficiaries and appeal technical denials. However, in reviewing these provisions, we believe that the fundamental issue is balancing due process considerations with administrative considerations. These changes would likely increase the number of appeals and their associated administrative costs. As indicated previously, the Medicare administrative structure is already strained to meet the current workload. It is also important to consider in a program as complex as Medicare whether beneficiaries need assistance in identifying and pursuing appeals of claims that have been denied.

Finally, we would like to suggest that you consider two other proposals in this area. First, we would urge that demonstrations of certain private sector approaches to the review of the appropriateness and cost-effectiveness of services be conducted under Medicare. In particular, we recommend demonstrations to test the feasibility and advisability of instituting a "prior approval" review process for the review of skilled nursing facility and home health admissions. In our private business, the pre-admission review of hospital services is an important and extremely effective component in our managed care programs. That experience could be applied to Medicare post-hospital care in a way that both improves the predictability of the process for beneficiaries and providers and helps assure that program funds are safeguarded. We believe that an effectively operated "prior approval" process may be a more appropriate long term solution to the problem of retroactive denials than continuing indefinitely the waiver of liability mechanism.

We would also suggest demonstration of "individual benefits management" under which an intermediary would consult with hospitals, SNFs and home health agencies, in conjunction with the patient and attending physicians, and approve payment for otherwise non-covered Medicare services where medically indicated, where appropriate to the beneficiary's needs, and where substitution of services would not result in additional costs to Medicare. Again, this is a mechanism that is used very effectively by a number of Blue Cross and Blue Shield Plans in their private business and may be appropriate for use in Medicare.

Second, we would urge greater attention to beneficiary and provider education. Such education could reduce the need to pursue appeals and help reduce the number of claims that are filed improperly. This relates to the funding issue, however, since beneficiary and provider communications activities are under severe funding constraints currently. In fact, unlike our private business, Medicare does not fund provider education programs at the intermediary level.

Study to Assist in the Development of a Long-Term Strategy for Quality Assurance

We strongly support this provision. There is a need for a thorough review of quality assurance from a reimbursement policy standpoint, from the perspective of the hospital conditions of participation and accreditation programs, from the claims and medical review perspective, and possibly from the perspective of patient outcome measures. Blue Cross and Blue Shield Plans, in their private business, are increasingly looking into this area as they develop PPOs and other mechanisms that encourage patients to use cost effective providers. In these efforts it is critically important to assure that such providers have adequate quality control processes in place and that appropriate external mechanisms, such as JCAH, act to periodically review quality of care rendered in individual hospitals. We would be pleased to participate in this study in any way we can.

Conclusion

In conclusion Mr. Chairman, we are encouraged by H.R. 4838. It places needed emphasis on quality of care and establishes mechanisms to address a number of concerns that have been raised regarding Medicare policies and procedures relating to post-hospital SNF and home health care. We have suggested some further proposals that you might consider, and we would be pleased to help the Subcommittee as you pursue this issue.

Thank you. I will be pleased to answer any questions.

Chairman STARK. Ms. McBroom.

## STATEMENT OF AGNES C. McBROOM, R.N., PRESIDENT, AMERICAN ASSOCIATION FOR CONTINUITY OF CARE

Ms. MCBROOM. I appreciate the opportunity to provide testimony regarding the pending legislation "Medicare Quality Protection Act of 1986." I am Agnes C. McBroom, president of the American Association for Continuity of Care, which is a national organization of 1,200 discharge planners and continuity of care professionals. I am also director of patient and family services at Valley Presbyterian Hospital in Van Nuys, CA, which includes the responsibility of discharge planning, social services and utilization review, and have been in discharge planning since 1965.

The American Association of Continuity of Care, or AACC, was formed in 1982 following an effort of discharge planners to establish a multidisciplinary organization for continuity of care. We believe that continuity of care is an essential component of the health care delivery system, and that every patient has the right to quality coordinated discharge planning.

The importance of discharge planning functions in hospitals cannot be overemphasized. It is not only a right for patients to have their needs for posthospital care evaluated and services arranged but also now is the critical component in the health care delivery system that provides for continuity of services and appropriate care in the community.

Discharge planners have actively advocated the importance of their services, not only as the necessary link to appropriate quality posthospital care but also as the driving force in cost containment for hospitals, the government and other payers. Without compromising quality, services can and are being provided in alternative health settings. Discharge planning functions, however, are not being provided uniformly across this nation. The issues of premature discharge, discharge "quicker and sicker" and "no care zones" have created an awareness that a discharge planning system that ensures identification, evaluation and implementation of a plan for appropriate care is essential to provide access to appropriate and necessary posthospital services.

Requiring discharge planning as a condition of participation will ensure that the provision of discharge planning services will be performed uniformly throughout the Nation by all hospitals participating in Medicare.

It must be recognized, however, that discharge planning will not and cannot solve the problem of lack of support services in the community. Medicare payment for care in skilled nursing facilities and by home health agencies is based on limited guidelines for skilled care and restorative services.

Medicare beneficiaries who require long-term or supportive care to meet their needs of daily living will still not have access to Medicare paid benefits. For those individuals the discharge planner can only provide referral to alternative community agencies for support services such as homemaker, attendant care, meals to the homebound and, when necessary, to agencies for financial assistance.

National statistics regarding factors influencing access to posthosptial care are in the process of being gathered by the General Accounting Office. However, information received from our constituents throughout the 10 regions of the country indicates that Medicare payments for posthospital care services and approved hospital length of stay varies widely from State to State. In many areas, long lengths of hospital stay existed and was acceptable before prospective payment. Since this is no longer economically feasible to hospitals and the Medicare Program, there needs to be a uniform approach to posthospital care services and an improved definition of Medicare-approved care.

The American Association for Continuity of Care supports the inclusion of discharge planning as a Medicare condition of participation in this legislation, and applauds the committee for recognizing the value of discharge planning as essential to quality continuity of patient care.

We thank you for the opportunity to participate in the development of the legislation which will further cement discharge planning and continuity of care for the patient. We offer our continued support and our advice to these efforts.

[The statement of Ms. McBroom follows:]

**STATEMENT OF THE**

**AMERICAN ASSOCIATION FOR CONTINUITY OF CARE**

I appreciate the opportunity to provide testimony regarding the pending legislation "Medicare Quality Protection Act of 1986."

I am Agnes C. McBroom, R.N., P.H.N., President of the American Association for Continuity of Care, which is a national organization of 1,200 discharge planners and continuity of care professionals.

We believe that continuity of care is an essential component of the health care delivery system and that every patient has the right to quality, coordinated discharge planning. I am also Director of Patient & Family Services at Valley Presbyterian Hospital in Van Nuys, California, and am responsible for Discharge Planning, Social Services and Utilization Review. I have been in hospital discharge planning since 1965, and continue to provide direct discharge planning services.

The American Association for Continuity of Care (AACC) was formed in 1982 following a grassroots effort by discharge planners to establish a multidisciplinary organization for continuity of care. AACC represents discharge planners and continuity of care professionals nationally with the majority of its 1,200 members being hospital-based. Our members are working daily to provide appropriate alternatives of care (facilities, services or supplies) for the post hospitalized patient. This includes the counseling of patients and family members on their role, what they can expect and how they need to be supported in order to provide the necessary support to the patient.

The discharge planners are also responsible for providing information to the patient on third party reimbursement and how that system works for each patient.

Members of the American Association for Continuity of Care are generally hospital employees whose sole interest is the patient and the patient's access to all the needs necessary for continued post-discharge care.

The importance of discharge planning functions in hospitals cannot be overemphasized. It is not only a right for patients to have their needs for post hospital care evaluated and services arranged but also now is the critical component in the health care delivery system that provides for continuity of services and appropriate care in the community. Discharge planners have actively advocated the importance of their services not only as the necessary link to appropriate quality post-hospital care but also as a driving force in cost containment for hospitals, the government and other payors. Without compromising quality, services can and are being provided in alternative settings such as through home health care and in skilled nursing facilities.

Discharge planning functions, however, are not being provided uniformly across this nation. The issues of premature discharge, discharge "quicker and sicker" and "no care zones" have created an awareness that a discharge planning system that ensures identification, evaluation and implementation of a plan for appropriate care is essential to provide access to appropriate and necessary post-hospital care. Requiring discharge planning as a Condition of Participation will ensure that the provision of discharge planning services will be performed uniformly throughout the nations by all hospitals participating in the Medicare Program.

It must be recognized, however, that discharge planning will not and cannot solve the problem of lack of support services in the community. Medicare payment for care in Skilled Nursing Facilities and by Home Health Agencies is based on limited guidelines for skilled care and restorative services. Medicare beneficiaries who require long term or supportive care to meet their needs of daily living will still not have access to Medicare paid benefits. For those individuals the discharge planner can only provide referral to alternative community agencies for support services such as Homemaker, Attendant care, Meals to the Homebound and when necessary to agencies for financial assistance.

National statistics regarding factors influencing access to post hospital care are in the process of being gathered by the General Accounting Office. However, information received from our constituents throughout the ten regions of the country indicates that Medicare payments for post hospital care services and approved hospital length of stay varies widely from state to state. In many areas, long lengths of hospital stay existed and was acceptable before prospective payment. Since this is no longer economically feasible to hospitals and the Medicare program, there needs to be a uniform approach to post hospital care services and an improved definition of Medicare approved care.

Currently 11.3 million or 4.8% of our population is 75 years or older. It has been projected that this number will increase to 17.2 million or 6.4% of the population by the year 2000. Services to the frail elderly will need to be redefined and improved upon to avoid unnecessary and costly institutional care. Discharge planning for Medicare beneficiaries will provide the vehicle to avoid unnecessary institutional care as well as to improve access to appropriate community services.

The American Association for Continuity of Care supports the inclusion of discharge planning as a Medicare Condition of Participation in this legislation and applauds the Committee for recognizing the value of discharge planning as essential to quality continuity of patient care.

The American Association for Continuity of Care thanks you, Mr. Chairman, for the opportunity to participate with the development of legislation which will further cement discharge planning and continuity of care for the patient. We offer our continued support and advice to these efforts.

Chairman STARK. Thank you very much. We will recess for about 5 or 6 minutes.

[Recess.]

Chairman STARK. I apologize for the longest 5 minutes you have ever had to wait.

Ms. McBroom, you were finished.

Ms. Cushman.

**STATEMENT OF MARGARET J. CUSHMAN, M.S.N, R.N., EXECUTIVE VICE PRESIDENT, VISITING NURSE AND HOME CARE, WATERBURY-HARTFORD, CT, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE**

Ms. CUSHMAN. My name is Margaret Cushman. I am the executive vice president of Visiting Nurse and Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the secretary of the board of directors for the National Association for Home Care, NAHC, and as the chairman of NAHC's Government Affairs Committee.

NAHC is the Nation's largest association representing home care professionals and paraprofessionals with approximately 3,000 member organizations. On behalf of these organizations, I would like to commend you for holding this important hearing.

The Medicare Quality Assurance Act of 1986, companion bills S. 2331 and H.R. 4638, are pieces of legislation that would go a long way in improving the quality of care Medicare beneficiaries receive and in assuring that they are cared for in the most appropriate health care setting. In particular, we are pleased that provisions are included which would facilitate appropriate transfers from hospitals to home health agencies—HHA's—and improve the administrative mechanisms for determining Medicare coverage. NAHC supports the legislation and will assist in working toward its enactment.

There is no longer any question that the hospital diagnosis related group—DRG—prospective payment system is having a profound impact on the number and types of patients being seen by HHA's.

There are numerous studies emerging that prove that DRG's are causing earlier discharges of patients who often have not been given sufficient time for their conditions to stabilize. Today's home care patients have a greater need of higher acuity services than in the past.

At the very time DRG's have been pushing sicker patients out of the hospital and into HHA's in greater numbers than ever before, the administration has embarked upon a systematic effort to dismantle the Medicare home health benefit. This attempt is documented in a March 19, 1986, report to Congress prepared by NAHC, entitled "The Attempted Dismantling of the Medicare Home Health Benefit."

We would be happy to provide you with additional copies, if you so desire.

S. 2331 and H.R. 4638 are important steps toward preventing the dismantling of the Medicare home health benefit, and assuring that beneficiaries are not denied the care in their homes that they are entitled to.

NAHC supports discharge planning as an integral process in assuring continuity of care for Medicare beneficiaries and other hospital patients. For those few hospitals that do not have a formal discharge planning program, it is not unreasonable to require it as a condition of participation. Absence of discharge planning can create serious placement problems for those ready to leave the hospital.

With regard to the extension of the waiver of liability provisions to certain coverage denials for home health services, NAHC supports extending waiver of liability coverage to so-called technical denials based on homebound or intermittent care requirements.

A problem that is likely to arise under this provision is that Medicare coverage denials will increase to a level over 2.5 percent of claims submitted. Therefore, many HHA's could lose their waiver status completely unless the 2.5 percent figure were adjusted upward, since technical denials are not currently part of the computation of the 2.5 percent.

Since fiscal intermediaries—FI's—have increased the number of technical denials as of late—for example, during the first quarter of 1986, 33 percent of all denials received by providers in Oklahoma were technical, while in 1985 only 5 percent were technical—extending waiver in this manner will almost surely push the denial rate for HHA's over 2.5 percent.

We therefore recommend that the waiver threshold be raised to 5 percent for HHA's. This would make the level equal to that for SNF's.

In addition, we applaud the development of a uniform needs assessment instrument. NAHC agrees that we need to take a closer look at examining and developing a better uniform needs assessment instrument for determining Medicare coverage of HHA services. The current mechanism results in inconsistent, arbitrary denials of coverage, in part because such terms as "homebound" and "intermittent" are so vague and open to many varying interpretations among FI's.

It is all the more important that we open up debate on this issue because the types of patients HHA's are now seeing after a hospital stay are much different from those that were seen when the Medicare home health benefit was first enacted. For example, because DRG's are pushing people out of the hospital in a sicker, more unstable condition than in the past, the intermittent care requirement may no longer be appropriate. This requirement essentially demands that the patient must not be "too sick." He or she must need care intermittently, as opposed to on a full-time basis. Patients who need care more frequently than on an intermittent basis are thought too sick to be cared for at home and should be in a nursing home. This, of course, makes no sense as a matter of public policy, particularly in light of the impact of DRG's.

First, HHA's are presently caring for individuals on a full-time basis when supported by non-Medicare payment sources. Second, nursing home care is not a viable option. Few people qualify for such care under Medicare. Third, if neither home care nor nursing home care are available, the ultimate effect is to leave individuals who are in need of health care to fend for themselves.

Without question, current coverage guidelines and criteria must be reviewed. There must be a better way to determine accurately and predictably whether a patient is in need of home health services under Medicare.

With regard to the expedited review by fiscal intermediaries, probably the biggest problems facing HHA's under Medicare at present concern widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted. Delays of well over 120 days have been reported this year by home care providers throughout the country. The resultant cash-flow problems that this has caused has rendered numerous providers unable to meet their payrolls.

After an agency submits a claim for payment, it continues to provide Medicare services even if payment is delayed extensively. If the claim is denied months after it is submitted, the agency may well have incurred additional expense for months of additional services. However, the agency is not permitted to turn around and bill the patient for the services rendered. Rather, the facility must take a loss, or "eat" the cost.

We are pleased that this provision reflects a sensitivity to this problem. We do request consideration be given to defining "expedite" and "minimize" within that provision so we can see they are implemented.

We also support the beneficiary being able to designate the provider for appeal rights, which has been addressed to by several others, and including annual reports on prospective payment information on quality posthospital care. We are supportive of the entire bill. We wish to support your efforts.

[The statement of Ms. Cushman follows:]

Testimony of

**Margaret J. Cushman, MSN, RN**
Executive Vice President
Visiting Nurse And Home Care
Waterbury-Hartford, Connecticut

on behalf of the
National Association for Home Care

Mr. Chairman and Members of the Committee:

My name is Margaret Cushman. I am the Executive Vice President of Visiting Nurse And Home Care, serving the Hartford-Waterbury region of Connecticut. I also serve as the Secretary of the Board of Directors for the National Association for Home Care (NAHC), and as the Chairman of NAHC's Government Affairs Committee. NAHC is the nation's largest association representing home care professionals and paraprofessionals with approximately 3,000 member organizations. On behalf of these organizations, I would like to commend you for holding this important hearing.

The Medicare Quality Assurance Act of 1986, Companion bills S-2331 and H. R. 4638, are pieces of legislation that would go a long way in improving the quality of care Medicare beneficiaries receive and in assuring that they are cared for in the most appropriate health care setting. In particular, we are pleased that provisions are included which would facilitate appropriate transfers from hospitals to HHAs and improve the administrative mechanisms for determining Medicare coverage. NAHC supports the legislation and will assist in working towards its enactment.

There is no longer any question that the hospital diagnosis related group prospective payment system is having a profound impact on the number and types of patients being seen by HHAs.

There are numerous studies emerging that prove that DRGs are causing earlier discharges of patients who often have not been given sufficient time for their conditions to stabilize. Thus, today's home care patients have a greater need of higher acuity services than in the past. A study of data from the Health Care Financing Administration, conducted by the Senate Special Committee on Aging reported a 37 percent increase in discharges from hospitals to HHAs because of DRGs. A February 1985 report from the U. S. General Accounting Office found that discharges of hospital patients to HHAs had increased since DRGs in over 83 percent of the agencies surveyed. A study by the Southwest Long Term Care Gerontology Center observed a 196 percent increase in HHA skilled nursing services that had to be provided after DRGs. University of Virginia researchers reported on the 27.5 percent increase in the intensity of home care services needed by beneficiaries because of DRGs. In a survey recently conducted by NAHC of 2,100 Medicare-certified HHAs, 92 percent responded that DRGs had resulted in a sharp increase in the number of sicker patients requiring intensive medical or nursing care. Finally, the Office of the Inspector General released a report in March, 1986 finding that "it is apparent that occurrences of premature discharges and inappropriate transfers do exist." There is no longer any question that DRGs are having a very significant effect on the need for home care.

At the very time DRGs have been pushing sicker patients out of the hospital and into HHAs in greater numbers than ever before, the Administration has embarked upon a systematic effort to dismantle the Medicare home health benefit. This attempt is documented in a March 19, 1986 report to Congress prepared by NAHC, entitled "The Attempted Dismantling of the Medicare Home Health Benefit." Chapter IV, "The Chronology of the Attempted Dismantling of the Medicare Benefit," describes in detail the barrage of administrative actions designed to restrict services and undercut the benefits promised to senior and disabled citizens under the Medicare law. These initiatives include:

- Attempted Removal Of Waiver Of Liability Provision
- Restrictive and Inconsistent Application Of The "Intermittent Care" Requirement
- Selective Billing - Barriers To Coordination of Benefits
- Disallowances of Appropriate Administrative Costs
- New Plan Of Treatment and Documentation Guidelines Forms 485-488
- Design and Implementation of a System of Ten or Fewer Intermediaries for Home Health Agencies

- New Coverage and Compliance Review Guidelines and Audits
- Inability of HHAs to Appeal Claims Paid Under Waiver
- Failure to Pay Claims When HHA is Under Waiver
- HCFA's Failure to Use Standard Statistical Standards of Validity and Reliability in Permissible Sampling Methodologies
- New Bonding and Escrow Requirements
- Lack of Adequate Standards for Fiscal Intermediaries
- Lack of Clear Standards in the Periodic Interim Payment Program
- Increasing, Excessive, Inconsistent Denials of Coverage

We would be pleased to make the entire report available to any Member of Congress, or include any or all of the report in the record for this hearing. We believe it supplies incontrovertable evidence of the Administration's intent.

S. 2331 and H.R. 4638 are important steps toward preventing the dismantling of the Medicare home health benefit, and assuring that beneficiaries are not denied the care in their homes that they are entitled to. We believe the Administration's regulatory cutbacks have betrayed the intent of Congress to make these services available to the elderly. The legislation proposed here will clarify Congressional intent that cost efficient, humane home care should not be effectively eliminated from the Medicare program.

The following is an analysis of Title II of the legislation "Access to Appropriate Post-Hospital Care." The analysis will go through the Title section by section:

Section 201 - Requiring Hospitals to Provide Discharge Process

NAHC supports discharge planning as an integral process in assuring continuity of care for Medicare beneficiaries and other hospital patients. For those few hospitals that do not have a formal discharge planning program, it is not unreasonable to require it as a condition of participation. Absence of discharge planning can create serious placement problems for those ready to leave the hospital. It has become an indispensable part of the services provided by the hospital.

Section 202 - Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services

NAHC supports extending waiver of liability coverage to so-called "technical" denials based on homebound or intermittent care requirements. These requirements are subject to the same vagaries as the policies governing medical necessity determinations, which of course, are covered by the waiver. The nature of these "technical" denials will be discussed in greater detail in the analysis of Section 207.

A problem that is likely to arise under this provision is that Medicare coverage denials will increase to a level over 2.5 percent of claims submitted. Therefore, many HHAs could lose their waiver status completely unless the 2.5 percent figure were adjusted upward, since "technical" denials are not currently part of the computation of the 2.5 percent. Since fiscal intermediaries (FIs) have increased the number of "technical" denials as of late (for example, during the first quarter of 1986, 33 percent of all denials received by providers in Oklahoma were "technical", while in 1985, only 5 percent were "technical") extending waiver in this manner will almost surely push the denial rate for HHAs over 2.5 percent. We, therefore, recommend that the waiver threshold be raised to 5 percent for HHAs. This would make the level equal to that for SNFs. There is no reason to make any distinction between the two. With HHAs shifting to a system of ten new regional intermediaries, it is particularly important that the waiver threshold be increased to 5 percent so that providers won't lose their waiver as they adapt to the differing interpretations of the Medicare regulations and guidelines for their new FIs. If Section 202 is passed without increasing the threshold to 5 percent, the net effect will be counterproductive, in that more and more HHAs will lose their waiver status. We would also recommend that other types of "technical" denials, such as failure to meet residence requirements and denials for dependent services (i.e., home health aide, medical social work) be included under Section 202.

Section 203 - Continuing of Favorable Presumption of Waiver of Liability for Skilled Nursing Facilities and Home Health Agencies

The waiver presumption was placed in the law to protect providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated. In these cases, the Medicare program does nothing more than make the provider whole.

In the home health setting, in order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of the Medicare services given. Any agency which exceeds this limit is not reimbursed irrespective of whether it accepted beneficiaries and acted in good faith. This requirement forces an agency to use due diligence in determining eligibility.

The Consolidated Omnibus Reconciliation Act of 1986 (COBRA) included a provision which would preserve the waiver presumption for HHAs for a year after the new 10 regional intermediaries for HHAs are all operational. After this time the waiver would be eliminated. NAHC strongly supports this provision which would make the waiver of liability permanent. Eliminating the waiver would serve to further undermine both the public and provider confidence in the Medicare program. It would make accepting Medicare patients a kind of "Russian Roulette" at a time when more rather than less certainty and predictability is required. Medicare beneficiaries are particularly concerned that the elimination of the waiver of liability will reduce their access to home health services and increase their out-of-pocket costs for these services because providers will be discouraged from accepting patients for all but those services sure to be covered. Given the vague appplication of constantly changing guidelines, directives, and regulations, it is difficult for HHAs to be 97.5 percent perfect in their determination of eligibility. Removing this requirement would demand that they be 100 percent perfect in their determination or suffer accordingly. Again, NAHC believes Congress should restore the more realistic 5 percent rate of permissible error previously in law.

Section 204 - Development of Uniform Needs Assessment Instrument

NAHC agrees that we need to take a closer look at examining and developing a better uniform needs assessment instrument for determining Medicare coverage of HHA services. The current mechanism results in inconsistent, arbitrary denials of coverage, in part, because such terms as "homebound" and "intermittent" are so vague and open to many varying interpretations among FIs.

It is all the more important that we open up debate on this issue because the types of patients HHAs are now seeing after a hospital stay are much different from those that were seen when the Medicare home health benefit was first enacted. For example, because DRGs are pushing people out of the hospital in a sicker, more unstable condition than in the past, the "intermittent" care requirement may no longer be appropriate. This requirement essentially demands that the patient must not be "too sick". He or she must need care intermittently, as opposed to on a full-time basis. Patients who need care more frequently than on an intermittent basis, are thought too sick to be cared for at home and should be in a nursing home. This, of course, makes no sense as a matter of public policy particularly in light of the impact of DRGs. First, HHAs are presently caring for individuals on a full-time basis when supported by non-Medicare payment sources. Second, nursing home care is not a viable option. Few people qualify for such care under Medicare. Third, if neither home care nor nursing home care are available, the ultimate effect is to leave individuals who are in need of health care to fend for themselves.

Without question, current coverage guidelines and criteria must be reviewed. There must be a better way to determine accurately and predictably whether a patient is in need of home health services under Medicare. The Advisory Panel and Report to the Secretary are appropriate measures for addressing this issue, given the complexity and importance of these deliberations.

Section 205 - Expedited Review by Fiscal Intermediaries

Probably the biggest problems facing HHAs under Medicare at present concern widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted. Delays of well over 120 days have been reported this year by home care providers throughout the country. The resultant cash flow problems that this has caused has rendered numerous providers unable to meet their payrolls. To date, we have received reports from the states of California and Illinois that several providers were forced to put their agencies up for sale because of this problem. In a survey conducted recently by the Louisiana Home Health Association, 18 percent of the respondents reported that they had not received Medicare payments in over 120 days. Two agencies reported that they were owed more than $300,000 each. In Oklahoma, many agencies received denial notices in March 1986 for services rendered and claims submitted in November 1985.

After an agency submits a claim for payment, it continues to provide Medicare services even if payment is delayed extensively. If the claim is denied months after it is submitted, the agency may well have incurred additional expense for months of additional services. However, the agency is not permitted to turn around and bill the patient for the services rendered. Rather, the facility must take a loss, or "eat" the cost. Thus, when coverage determinations are delayed, thousands of dollars worth of potential revenues are lost; whereas, if determinations are made promptly, within 30 days, the agency has the option of billing the patient for subsequent services and is not forced to take such massive losses.

We are pleased that this provision reflects a sensitivity to this problem. However, the terms "expedite" and "minimize" are not defined. This vagueness weakens the intent of the Section, since an expedited disposition could be interpreted to mean 90 days, as opposed to 120 days. Our primary concern with this provision, however, is the lack of any enforcement mechanism to ensure that these procedures are followed. Without such an enforcement mechanism, FIs will be able to ignore this provision and unreasonable delays will continue. We do not believe that a change in or addition to the Contractor Performance Evaluation Program (CPEP) would suffice because the bias in this program towards cost savings will still vastly outweigh any such provision (CPEP problems are discussed below). Rather, some form of financial incentive, such as paying interest after 20 days, could be required to give this important provision some teeth. On the whole, however, NAHC supports the thrust of this section and looks forward to working with the Committee to strengthen it in the ways described above.

Section 207 - Provider Representation of Beneficiaries on Appeals and Permitting Appeal of Certain Technical Denials

NAHC considers Section 207 to be the most important provision for home care providers in this legislation. It addresses two of the most grossly unfair rules under the Medicare home health benefit, which have plagued beneficiaries and providers alike.

NAHC continues to press for the right of a patient to elect to have a Medicare provider represent him in the claims denial process. The selection of a HHA as a beneficiary's representative was acceptable for many years until HCFA issued a revised manual provision (Section 257A.1--HIM-11) blocking the exercise of fair hearing rights for Medicare beneficiaries. These individuals are frequently unable from a practical and medical viewpoint to handle the taxing requirements which are part of the claims denial and the appeals process. The HHA has traditionally served as a medical and emotional support for these people and is frequently in the best position to know and represent the patient's medical needs in the appeals process. NAHC was extremely supportive of the provision in the Budget Reconciliation Act of 1986, which would have permitted provider representation. Unfortunately, under pressure from the Office of Management and Budget, the provision was deleted. NAHC is very pleased to see this issue addressed here.

When terms like "homebound" and "intermittent" directly relate to medical orders which physicians sign to permit HHAs to render care under the home health benefit, and to the medical and nursing assessments of the patients which the HHA must perform on an ongoing basis, the HHA should have the right to appeal such denials directly. Medicare beneficiaries rely upon the medical and nursing assessments of the HHA, and the HHA relies upon the patient for accurate information about the patient's activities and subjective responses to treatment. HCFA's "technical" denial policy fractures this relationship of caregiver and patient and is an illogical interpretation of the statute as now written.

NAHC believes HCFA's "technical" denial policy is another attempt to create Medicare "savings" because HCFA is aware that most Medicare patients, their families or survivors may lack either the understanding or the stamina to appeal a "technical" denial on their own. It is simply not realistic for HHAs to expect or even attempt to recoup from frail people in strained financial and emotional situations the costs of months of care disallowed by FIs. Having already paid staff salaries, HHAs are left with tremendous financial losses.

The Medicare beneficiary is harmed since the HHA which rendered care is barred by current HCFA policy from joining in or leading the appeal. Medicare beneficiaries are also adversely affected because HHAs facing severe monetary losses from "technical" denials must avoid care of patients whose care might result in a "technical" denial. For example, most technical denial cases on the "not intermittent" care issue are won by patients at the impartial administrative law judge level.

However, HHAs cannot be confident that these appeals will be brought by sick, exhausted patients or bereaved families. HHAs will begin to limit the number of these patients, or cut back on needed visits, or simply not bill for visits that are made - which no business can afford to do for long. The result is an inevitable narrowing of the Medicare home health statutory benefit, and just at the time when doctors and Medicare beneficiaries are relying more heavily on HHAs to provide post-hospital care.

NAHC congratulates and thanks Chairman Stark and his staff for including Section 207 in this bill, as it will help senior citizens to receive the Medicare home care services they have been promised.

Section 208 - Including in Annual Reports on Prospective Payment Information on Quality of Post-Hospital Care

NAHC supports this provision. It will help Congress to ensure that its objectives are being met and that HCFA is not disregarding clear guidelines to make high quality Medicare home care services accessible to beneficiaries.

On the whole, NAHC is very supportive of the goals and methods of the Medicare Quality Assurance Act of 1986. We do have several recommendations, however, for additional provisions that are not included in the current bill, but, are very relevant to the issues addressed in Title II. These recommendations are to: (1) permit HHAs to aggregate (average out) their costs under the Medicare cost limits; (2) improve FI incentives in making Medicare HHA coverage decisions; (3) prevent HHS/HCFA from circumventing the regulatory process; (4) define intermittent care in a manner consistent with H.R. 2371; (5) prevent HCFA from using outdated data in computing cost limits; and (6) create an advisory panel to ensure that medical claims reviewers have appropriate clinical backgrounds and training and to conduct investigations and assessments of these reviewers' performance.

These five recommendations are discussed in turn:

(1) Medicare HHA Cost Limits

On July 3, 1985 HCFA published a final rule which radically altered the way in which home health cost limits are calculated under Medicare. While cost limits were previously set at the 75th percentile of aggregate agency costs, the rule required HHA limits to be set at 120% of the mean of visit costs in six separate disciplines (and 113% as of July 1, 1986), explicitly disallowing aggregation, or averaging out of these costs.

NAHC requests that HHAs be permitted to aggregate their costs under the limits and that the GAO conduct a study on the impact of the limits and effect of disaggregation on beneficiaries and HHAs. Without such relief, over 70% of HHAs would exceed the limits in at least one discipline; high technology and other costly services would be severely limited or not offered at all; new and rural agencies would be hard hit; agencies would be forced to deny access to "heavy care" patients; the level of paperwork would increase dramatically; the quality of care will be reduced because agencies will be forced to dismiss their tenured employees, hiring less experienced personnel; and the amount of indigent care received would be reduced sharply. NAHC is currently conducting a survey on the impact the cost limits have had so far. Results from this survey should be available in approximately 3 to 4 weeks.

(2) Performance Standards for FIs

NAHC strongly supports provisions in House Aging Committee Chairman Edward Roybal's Medicare Continuing Care Equity and Quality Assurance Act of 1986 (H.R. 4330). Current performance evaluation standards for FIs are biased towards cost savings over accuracy. Therefore, in grey area cases, FIs have strong incentives to deny coverage so that they will receive high ratings on their CPEP. The provisions in H.R. 4330 that NAHC supports and urges be included in the legislation under discussion:

- Requires that DHHS develop new criteria and standards for evaluating intermediary performance under the CPEP that:

(1) Give equal weight to "accuracy" as to "cost savings" in intermediary decisions under both their medical claims review and cost report review and cost report review functions.

(2) Establish "accuracy" and "timeliness" in both medical claims review and cost report review as critical variables such that failure to meet standards under these, as with other CPEP critical variables, is grounds for termination of contract.

(3) Replace the current 3:1 minimum standard for cost-savings under the medical claims review and cost report review functions with measures and standards of cost-effectiveness that are not based on numerical standards alone.

(4) Increase the weighting of performance criteria related to the completeness of explanations for denials under both medical claims review and cost review functions.

- Requires that DHHS set conditions for granting continuing care providers a presumptive right of reassignment to an alternate fiscal intermediary based on patterns of delays in claims processing, payment, or other indications of poor performance.

- Requires that DHHS provide information on overall intermediary performance (such as data on claim denials and reversals by region and intermediary including decisions from Administrative Law Judge and judicial proceedings) for the purpose of evaluating and revising criteria under the CPEP.

(3) HHS/HCFA Circumvention of the Regulatory Process

HHS/HCFA have undertaken numerous actions which circumvent and violate the regulatory process. HCFA, for example, often issues guidelines in its manuals or written or verbal policy directives making substantive changes which should be published for comment in the Federal Register. Even when it does place potential changes in the Federal Register, this is only a pro forma effort, and fails to adhere to the requirement for an analysis of the rule's impact on small business, or publishes regulations in "interim final" form, impeding the opportunity for public comment. NAHC is strongly opposed to such violations of the regulatory process and will work with the Office of Management and Budget, when appropriate to identify such actions. This kind of HHS/HCFA conduct violates the Administrative Procedure Act, the Regulatory Flexibility Act, the Paperwork Reduction Act of 1980, and Executive Order 12291, and hinders the cost-effective and rational administration of HHAs and the Medicare program. We urge that this problem be addressed.

(4) Intermittent Care Definition

In order to qualify for Medicare home care benefits, a patient must be in need of "intermittent" as opposed to daily 24 hour-a-day care. Definitions of what constitutes "intermittent care" vary tremendously, depending on the FIs interpretation. Intermediaries have been inconsistent and increasingly more restrictive in their interpretations, with the result that Medicare patients are being deprived of the care they need and to which they are entitled. Thus, Medicare, which is supposed to be a national program, is not enforced uniformly, and what is covered for one beneficiary in one state is not covered in another state. The irony is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy and other services into the hands of home care agencies who are being told that they cannot care for them because they need more than intermittent care.

NAHC urges that legislation such as H.R. 2371 be adopted to define intermittent care to include one or more visits per day on a daily basis by a nurse or a home health aide for up to 90 days, and thereafter under exceptional circumstances, with monthly physician certification of reasonableness and necessity.

(5) Use of Outdated Cost Limit Data

NAHC is concerned that further shortchanging of Medicare beneficiaries will result if HCFA uses outdated cost data from FY 1983 cost reports to set HHA cost limits for cost-reporting periods beginning after July 1, 1986, as it evidently intends to do. First, these data fail to reflect the costs incurred by HHAs in

treating sicker Medicare patients discharged earlier from hospitals under prospective payment, which did not go into effect until October 1983. As more intensive care is being provided under the home care benefit, the cost per visit obviously has increased.

Furthermore, the 1983 cost report data also fails to take into account the experience of agencies that have entered the Medicare program since October 1982, as well as the costs that agencies have had to incur in complying with HCFA's new medical documentation requirements -- an administrative cost associated solely with billing for Medicare-covered services, which should appropriately be borne exclusively by the Medicare program.

Not only is HCFA intending to use outmoded on data base that no longer reflects the cost experience of HHAs providing care today, but HCFA plans to ratchet down last year's cost limits to 115 percent of the mean cost per visit per discipline.

Unless Congress intervenes to prevent HCFA from basing reduced limits on stale data, access to the Medicare home health benefit will be seriously eroded at a time when the demand for such services is growing because of other changes in the health care delivery system. NAHC proposes that Congress act immediately to prevent HCFA from implementing lower cost limits based on FY 1983 cost report data and that it be required to process expeditiously the FY 1984 cost report data so that newer and more accurate cost data can be used in computing appropriate cost limits.

(6) Advisory Panel on Claims Review Training

Far too many FI employees without adequate background or training are reviewing HHA claims for payment. For example, we should not permit a pediatric nurse to review home health claims for elderly patients, or a nurse without clinical experience for many years to review claims for therapy and other services. When such employees review claims, with a nursing degree as the only qualification for being hired, the chances for making an erroneous decision becomes grossly exacerbated. NAHC urges that a technical Advisory Panel be created, with members including provider, beneficiary, FI and HCFA representatives, to set training and qualification standards for these claims reviewers, and to investigate allegations of inappropriate personnel conducting claims reviews.

The ability of HHAs to deliver the necessary services patients require upon discharge has been seriously eroded by the recent actions of the Administration. At a time of increasing concern about the expenditure of Federal money on health services, home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans. NAHC supports the Medicare Quality Assurance Act of 1986 because it will help senior citizens to receive the appropriate post-hospital home care they so desparately need and prefer.

Mr. Chairman, I appreciate having this opportunity to testify today. I want to thank you for your efforts and concerns and would be happy to answer any questions you might have.

Chairman STARK. Thank you very much.
Dr. Willging.

## STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. WILLGING. I would like to commend you for having introduced a piece of legislation which speaks to a problem which was not recognized when the DRG system was first enacted. Specifically, for the system to work effectively, while at the same time protecting the health care rights of medicare beneficiaries, it must concern itself as much with the posthospital care setting as the hospital care setting itself.

We think the legislation you introduced Mr. Chairman, considered in concert with H.R. 4330, introduced by Congressman Roybal, will go a long way toward correcting some of the problems that have cropped up over the last couple of years.

In particular, we would support sections 201 and 204, the provision which requires discharge planning and the provision to develop a uniform needs assessment instrument.

We would suggest, however, there might be one or two logical steps that follow inevitably from these two provisions, such as the uniform criteria provision in Congressman Roybal's bill and the prior authorization provision, so as to get all of us, providers and beneficiaries, out from this twixt and tween land where no one knows until after the fact whether coverage is allowable.

We also support section 205, which would expedite the review processes, and section 207, which provides more benefits to the beneficiaries in terms of their representation for denied claims by allowing the provider to represent the beneficiary.

I think, however, Mr. Chairman, that when one looks at this legislation, and its beneficial provisions, there are certain inherent flaws and problems with the Medicare SNF benefit that should be looked at as well.

I think your mother raised one of the existential issues of the decade: "When is enough enough?"

I would clearly suggest that when a benefit at the outset is clearly not enough, when it is whittled down to one-fifth of its original size, it even more clearly is certainly not enough. Or, put differently, when does a 100-day benefit become a 30-day benefit?

Legislatively, the SNF benefit is 100 days. HCFA, in its wisdom, has made that an average benefit of 30 days, which is one-half the average length of stay by a medicare beneficiary in a SNF.

Now, as a result of the initial legislation, that 30-day benefit has become a 20-day benefit, because one-eighth of the hospital daily rate, which is the cost sharing after the 20th day in a SNF, is now more than the medicare payment to the SNF. After 20 days, the beneficiary has to pay out of pocket, for all intents and purposes, the entire cost of that stay. Thus, enough here is clearly not enough and I think that we have a clear area where the benefit, inadequate at the outset, has become even more so.

I am here also to suggest some of the provider problems in terms of inducements to participate in this program. While some of them would clearly be corrected by your legislation, others do remain.

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One example, Gramm-Rudman. I am not so naive as to take the position of the advocates of the Farm Loan Program; I would not propose exempting the SNF benefit from Gramm-Rudman. I would suggest, however, there is a certain—or I would suggest it, if I thought I could get your concurrence, Mr. Chairman——

Chairman STARK. I voted against it.

Mr. WILLGING. I find it intriguing that as the 1 percent reductions applied to the DRG program, the price paid for the hospital stay is reduced by 1 percent. In this case every hospital still has the theoretical ability to make a profit and cover costs.

SNF's are under a retrospective cost reimbursement program. With a cutback of 1 percent of the costs reimbursed to the SNF, every facility that is either altruistic enough or masochistic enough to participate in the SNF benefit under medicare is guaranteed a loss—only 1 percent, admittedly, but a loss notwithstanding.

I would suggest there might be other ways of achieving the same 1 percent——

Chairman STARK. They have to have more creative accountants than that.

One percent? They ought to be able to fudge that.

Mr. WILLGING. Who knows about the future? All things considered, I am looking forward to sitting with you on the Secretary's Advisory Commission on Catastrophic Health Care Costs.

Perhaps, in addition, through this and companion legislation dealing with some of the anomalies that have cropped up, I look forward to dealing with you in some of the broader issues in terms of this Nation's ability to deal with the health care needs of its elderly citizens.

[The statement of Mr. Willging follows:]

Statement by

Paul Willging, Ph.D.
Executive Vice President

AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA), the largest association representing America's long term care providers. AHCA's membership currently exceeds over 9,000 nursing homes, many of whom provide skilled nursing facility services under the Medicare program.

We appreciate the opportunity to present our views on H.R. 4638, the Medicare Quality Assurance Act of 1986, which was introduced by you, Mr. Chairman, and a Senate companion bill by Senator Heinz. It is clear that the focus of this legislation is directed towards improving the appropriateness of discharge of beneficiaries from hospitals. However, H.R. 4638 also refers to an equally serious problem which relates to the adequacy and availability of appropriate post-hospital care. Indeed, with hospital discharges to skilled nursing facilities having increased by 40 percent in the past 2 years, the need to look at the entire continuum is essential.

We believe the proposals of the Medicare Quality Assurance Act which pertain to patients' access to post-hospital care address an aspect of health care which has previously received little attention. The bill's provisions are significant and worthy of consideration. Our concern, however, is that as currently described in H.R. 4638, they may not go far enough. We would ask you to consider some of the proposals included in H.R. 4330, the Medicare Continuing Care Equity and Quality Assurance Act of 1986, introduced by Cong. Edward Roybal (D-CA). Although similar to H.R. 4638, this bill looks at access and quality with respect to long term care services and offers some specific reforms for improving that access in various settings. In view of the approach taken by H.R. 4638, the Roybal bill could be considered as a complement to your legislation.

I would now like to make the following recommendations about the provisions of H.R. 4638 which relate most directly to long term care. My remarks are given according to the order of the provisions as they appear in the legislation.

Section 106. Administratively necessary days.

We believe the focus of the proposed HHS study required in this section is misdirected. The proposal seems to imply that because alternative settings are not available to the beneficiary, "administratively necessary days" in a hospital are probable and that a study is needed to determine appropriate payment for such days. The study seems directed to the symptoms rather than the root problem -- the severe shortage of Medicare skilled nursing facility (SNF) beds. We believe that administratively necessary days should be reduced rather than accommodated. We recommend the study focus on mechanisms to assure appropriate post-acute care.

As an interim step, we recommend a proposal contained in H.R. 4330 which requires that HHS, in conjunction with a Continuing Care Policy Council, set standards, assess criteria and payment rates that permit Medicare-certified home health providers and licensed intermediate nursing home providers to provide care only if the possibility of continued hospital stay is ruled out, only when the Professional Review Organization (PRO) certifies that the patient's health and safety can be reasonably assured at the lower level of care, only when the patient or the patient's chosen representative and physician agree to the alternate care setting and only until a skilled nursing home bed becomes available. AHCA believes that Medicaid-certified skilled nursing facilities should also be permitted to provide care.

Sec. 203. Waiver of Liability

AHCA was pleased that the Medicare waiver of liability presumption for skilled nursing facilities and home health agencies was extended by the Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272). Not only does it give limited financial protection to health care providers who accept Medicare patients, but, more importantly, it protects the beneficiary's access to needed nursing home care. In the long term, however, we believe that permanent continuation of this practice, as proposed in H.R. 4638, will not solve the problem of unpredictable retrospective denials of claims.

In view of the growing number of beneficiaries being cared for in Medicare-certified SNFs and home health agencies, we believe a prior authorization system is a more innovative and needed approach. Such a system would reduce costs incurred by beneficiaries during the claims review process and inform providers prior to or during provision of services as to Medicare eligibility rather than after the fact.

For example, H.R. 4330 addresses this approach by establishing a system of prior and concurrent authorization that includes:

1. A presumptive eligibility period for the beneficiary and provider; and

2. A concurrent, 10-day claims review period for services claimed within a class of benefits.

Section 204. Uniform needs assessment instrument.

AHCA strongly endorses the development of a needs assessment instrument which can be used to evaluate an individual's need for post-hospital extended care, home health, and other long term care services. As indicated in H.R. 4638, this tool could be used by discharge planners, hospital and post-hospital providers and fiscal intermediaries. This proposal coincides with a recommendation made by the recently released Institute of Medicine (IOM) study on nursing home regulation.

As a complement to this concept, we believe that uniform criteria for medical claims review, as proposed in H.R. 4330, should also be considered. We believe it essential that judgment of Medicare coverage be made in a consistently objective way and that uniform criteria would facilitate such a process. In addition to serving as an assessment protocol with respect to patients, the mechanism could set qualifications for personnel employed to perform Medicaid reviews under Medicare.

Sec. 205. Review by fiscal intermediaries.

AHCA supports the development of an expedited review process which will minimize the time between when Medicare services are provided and when determination of payment is made to the provider.

Sec. 206. Prompt response to inquiries concerning exhaustion of Medicare SNF benefits.

AHCA strongly supports this provision.

Sec. 207. Provider representation of beneficiaries on appeals.

AHCA supports allowing beneficiaries to choose to be represented by the provider in appealing Medicare claim denial. In so doing,

protection is given to the right of Medicare beneficiaries to select freely their most competent representation for the claims appeal process. AHCA applauded the willingness of the House to include this provision in last year's budget reconciliation bill and regretted its elimination prior to final passage. We are pleased to see this proposal included in H.R. 4638.

Sec. 208. Prospective payment reports to include information on quality of post-hospital care.

AHCA strongly supports this proposal. As an adjunct to the provision, we would recommend the establishment of a Continuing Care Policy Council, as proposed in H.R. 4330, which would report to HHS regarding the development and interpretation of definitions, policies and regulations under Medicare's continuing care benefit.

Sec. 302. PRO review of quality of care.

AHCA is concerned about direct involvement of the PROs in the review of quality of care in skilled and intermediate care facilities and board and care facilities. The PRO system was established by Congress to conduct reviews in hospitals. We believe their primary responsibility should remain in acute care.

Current law states that both Medicare and Medicaid require evaluations of the quality of care provided nursing home residents and of the appropriate and efficient utilization of facility services for program beneficiaries. These "inspections of care" are a comprehensive quality assurance program for long term care facilities. Therefore, another layer of quality assurance in long term care by PROs is not needed.

The mechanisms already established by the states should be the primary mode of quality and utilization review in Medicare SNFs, Medicaid SNFs and ICFs. However, in some cases, the Peer Review Organizations may be in ideal positions to observe patterns of poor or inappropriate care in long term care facilities. Accordingly, the PROs should be required to refer these problems to the appropriate state and/or federal survey office.

Section 401. Strategy for quality review and assurance.

AHCA supports development of a long term quality assurance and review strategy, but we believe that this particular study should be limited to hospitals which provide services under Medicare.

The Institute of Medicine study was conducted to examine problems identified within the nursing home regulatory system. Representatives of consumers, providers and government agencies worked together over a 2-1/2 year period to develop recommendations which would correct these practices and contribute towards improved quality of care and well-being of nursing home patients. These recommendations would be applicable to both Medicare and Medicaid participating skilled nursing facilities as well as Medicaid participating intermediate care facilities.

AHCA cooperated with and contributed to the IOM study and endorses most of its recommendations. We believe the study provides an appropriate backdrop for a number of the long term care-related proposals contained in H.R. 4638 and many of those in H.R. 4330. Sufficient time should be allowed for administrative implementation of the IOM study recommendations. In addition, if enacted, the legislative proposals pertaining to long term care will serve as an accompaniment to these efforts to improve post-hospital care.

**Summary**

Recently, a number of bills have been introduced in Congress which attempt to address quality assurance in health care. The Medicare Quality Assurance Act, although focussed on hospitals, contains a number of proposals which address the post-hospital care issue. We believe these recommendations should be developed in concert with H.R. 4330 and the IOM study to assure an appropriate response to the need for change and improvement in post-hospital care. We applaud your efforts and attention to this important concern, Mr. Chairman, and we look forward to working with you and your subcommittee.

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Chairman STARK. Thank you very much.

I thank the entire panel, both for your patience and your understanding.

I wanted to ask Ms. McBroom, on the issue of discharge planners, who pays for that service?

Ms. MCBROOM. That is part of the administrative costs of the hospital.

Chairman STARK. Is there some inherent conflict of interest there? It would seem to me that if you worked too hard for the patient, then the hospital is going to lose money. In the first place, they might look to save money by getting rid of you.

I just wonder if the incentives are lined up the right way there?

Ms. MCBROOM. From my personal experience, I have been most fortunate working in an environment where administration leaves me alone. Granted, there are times when the patient does not leave the hospital because the plan is inappropriate. Yes, that does cost the hospital money.

But, fortunately, in many hospitals, administration does not bear pressure on the discharge planner. We are bound in our own profession to practice appropriately for patient care; not to send patients out of the hospital prematurely.

Chairman STARK. Are your members spread randomly across the board as to types of hospitals, as to profit, nonprofit, church-related, community?

Ms. MCBROOM. Yes.

Chairman STARK. So you are not a phenomena, say, of charitable hospitals alone?

Ms. MCBROOM. No.

Chairman STARK. As I say, I certainly can understand that there is professional ethics and standards. You are saying that that is sufficient to assure that—the discharge planners work for the right person—in this case, the beneficiary—if a choice must be made, rather than the hospital?

Ms. MCBROOM. That is correct.

Chairman STARK. It sure doesn't work here in Congress.

Ms. MCBROOM. We have had instances where patients were ready for discharge, and when the discharge planner identified an inappropriate home care situation, we have been responsible for holding the patient's discharge even at the expense of additional hospital days.

Chairman STARK. All right.

Mr. Spielman, do we need a demonstration project to study prior authorization systems for skilled nursing facilities and home health benefits?

Mr. SPIELMAN. The reason we suggest a demonstration is that most of the experience with prior approval has been with inpatient hospital services. While conceptually I think you can very easily transfer that same expertise over to posthospital care, one might want to demonstrate first.

Chairman STARK. You say we need a demonstration rather than reviewing the data available to us?

Mr. SPIELMAN. I wouldn't think it is a clear black and white situation. It could very well be that after further analysis of the data, you could conclude to do that right away.

I would point out, though, that the notion of prior approval is incompatable with a permanent extension of the waiver of liability. You would not want to have both. You would want to have one or the other.

But conceivably you could set a point, a date certain in the future, where such a better mechanism might be put in place.

Chairman STARK. One of the problems that concerns me about my own legislation is that we may just be building a paper tiger here that is just going to add lots of studies and homilies, and not really do a whole heck of a lot.

I gather you all would agree we have plenty of enforcement procedures in the bill which will produce some improvement without either interrupting the hospitals or——

Mr. WILLGING. Mr. Chairman, I think particularly on the prior authorization suggestion, I would respectfully disagree that we do need a demonstration. Prior to my employment at AHCA, I was the Deputy Administrator of HCFA. I recall that the Office of Direct Reimbursement dealt with prior approval issues both in the hospital and postacute care areas.

Prior approval can be done, particularly if it is used along with the requirements in the provisions of this and companion legislation and they are enacted. The provisions I'm referring to pertain to required hospital discharge planning and a uniform assessment mechanism.

Chairman STARK. If you require discharge planning, is it a simple thing to review the plan?

Mr. WILLGING. I would defer to my colleague. But I suspect that once a discharge planner has looked at the condition of the patient, looked at the need for service, and tried to isolate the appropriate modality in the community, he or she would likely say yes, this case requires, under Medicare's own coverage principle, so many days of home care, nursing home care, or the following therapies.

I am out of my element. I would defer.

Ms. MCBROOM. One of the problems we have identified across the country is the tremendous variance between fiscal intermediaries that pay for services provided in skilled facilities or by home health agencies. It would be very difficult for a discharge planner to say yes, you will be covered for 14 days in *x* skilled facility without knowing exactly who their fiscal intermediary was, and what their interpretation was for covered care.

The association looked at the concept of certification for the discharge plan within Senator Heinz' bill. It was the consensus of our opinion that this would create an undue burden on discharge planners who are already working very long hours, and are very actively trying to provide support care services for beneficiaries where they are nonexistent.

One of the major problems that we have identified as an association is not accessing the patient to the Medicare paid services. That is one of the easiest discharge plans to accomplish. The more complex issue is that of the frail elderly who does not have access for any long-term care or any supportive services.

Chairman STARK. Let me follow on that. I am beginning to think—and correct me if I am getting off in the wrong direction—that the issue is not the marginal extra day, as Dr. Moncrief sug-

gested. It is not "I would like to stay another day; I am a little tired." That is 10 to 20 percent of the issue. Eighty percent of the issue is a person who needs another 10 days, or a whole other facility.

The issue of a judgment call of whether they should be in the hospital 5 days or 4 days is not the major part of our problem. The major part is this other longer term and somewhat different care after the acute care hospital is finished.

Am I deluding myself? Is that a fair summary of how you see the problem?

Ms. CUSHMAN. I think you represent a fair summary of one group of patients, and a very real serious set of concerns.

It has been brought to my attention within our own agency. In the last couple months, we have been seeing another phenomenon. That is the patient who it is determined will not be admitted to the hospital. I don't want to make any decisions about whether or not the medical judgment in those instances are appropriate.

The types of patients who will not improve with hospitalization, but may be extremely ill, that is still another group of patients who——

Chairman STARK. Give me an anecdote.

Ms. CUSHMAN. An individual who has a terminal illness, end-stage, chronic disease, who has been in and out of the hospital episodically, the last 6 months to 2 years, is discharged from the hospital, return home, deteriorates within a month, is seen in the emergency room and the emergency room says we really can't do anything except the same stuff we have always done before; "You don't need to be admitted in the final stage of your illness." But they are very sick people.

Chairman STARK. Are they candidates at that time for a hospice?

Ms. CUSHMAN. The hospice benefit again is a very narrowly prescribed benefit.

Chairman STARK. Some hospitals in my area have a hospice program that includes home health care. Really, it is a visit and a hospice program, but for the most part, the person remains at home.

What do you do with that person? Is there a DRG they fit into? Do we turn them down?

Ms. CUSHMAN. There are a couple of parts to that. One of the problems with the hospice benefit is it is designed for patients in their last 6 months of life. With a group of these patients, I am sure you see in the skilled nursing facility, as well, and we see it at home, they are chronically ill for years and may be in very deteriorated condition. So, it doesn't fall neatly within that 6-month period.

Chairman STARK. Again, my instincts tell me that people that are seriously chronically ill don't last very long; they usually expire.

Ms. CUSHMAN. They don't as often as they used to. We have wonderful medical care.

Chairman STARK. Without a life-support system.

Ms. CUSHMAN. We have wonderful medical science that has prolonged these problems far beyond what we saw 5, 10 years ago.

Chairman STARK. I am not sure we address that here in this bill. I guess I can recognize the problem. My opponents have been saying that about me for years.

Ms. CUSHMAN. I think it is too new of a problem to realistically have gathered some of the types of data on it, that we need to address it.

Chairman STARK. What happens to this person? Do they end up in a charitable institution as a ward of the community?

Ms. MCBROOM. May I speak to that?

Chairman STARK. Yes.

Ms. MCBROOM. That is one of the challenges of the discharge planner, to counsel the patient and their family, to perhaps agree to either pay for care in a skilled nursing facility or at least guide them to access the Medicaid, or—in my State, the medical program, to pay for chronic care in a skilled nursing facility environment.

The Medicare benefit is very limited. In doing studies within my own department, only a very small percentage of our patients being transferred to skilled facilities actually qualified for benefits under the program.

The need for chronic, long-term care is rapidly increasing. When I began in discharge planning some 20 years ago, our average patient was between the ages of 65 and 75. Now our average patient exceeds the age of 80 to 90. The chronic care problems are rapidly expanding, but services paid for by the program have not met their needs.

Chairman STARK. I gather you are now touching on the issue of people having to pauperize themselves to qualify for what the rest of you would know as Medicaid.

What is your sense, Ms. McBroom? Do the patients object to that on the theory they won't have their house to go back to and they will lose their independence and become welfare cases? Or, as I often suspect of the kids who hope to inherit the house, they object to it?

Ms. MCBROOM. Very loudly, it is very difficult to sit down with a family who have had a Medicare book unopened for many years, and suddenly during a course of acute hospitalization they begin reading a book that they cannot interpret.

We will hear, "Medicare said they would take care of all of my needs."

Discharge planners spend a significant amount of time interpreting to the Medicare beneficiary and their family what is an actual benefit and what is a desire.

Chairman STARK. How many have been led to believe their Medigap policies are going to cover?

Mr. WILLGING. Seventy-nine percent, Mr. Chairman. The American Association of Retired Persons—and you heard its president testify today—did a survey, through the Gallup organization, of its membership, and asked them three questions:

One, would you buy long-term care insurance? The answer—79 percent, said no.

The second question: Why not? The answer—the same 79 percent said we have it already.

Third question: What do you have? We have Medicare.

The elderly do not know, until they deal with my colleague here or an administrator of a nursing home, that Medicare is a myth; the fact is there is no coverage for long-term care other than through the welfare program.

Chairman STARK. How many think their Medigap policies, the same policy as the AARP, will provide it for them?

Mr. WILLGING. Many have a combination of policies. Even those who realize Medicare doesn't cover long-term health care assume Medigap will.

Chairman STARK. My mother has eight of them. She said, "Your father bought them before he died." She will live on a grate before she gives them up.

Mr. WILLGING. Send her to Fireman's Fund. They will sell an honest to God long-term policy in California.

Chairman STARK. The skilled nursing facilities, for lack of a better word—nursing homes, which I would rather talk about as life-care rather than medical care—yes, I am beginning to suspect there are a lot of people out there that think our Medicare Program was intended to cover that, which to my knowledge it was not.

I am starting to read nasty articles about the fact that we are falling down on the job.

Mr. WILLGING. I am stimulating most of those articles.

Chairman STARK. Are you?

I would submit that you make Cap Weinberger look like a piker if you thought the Federal Government was going to pay for extended nursing home stays. We could buy six Star Wars machines.

Mr. WILLGING. In a way, the Federal Government is paying for it through its share in the Medicaid Program. The question is, Is that the most efficient way of paying for it?

Chairman STARK. If I thought Medicare would pay for mom's nursing home, it would be so much easier for me not to help support her in the home she is in. I would have to go see her on Sunday. She would lie to me and tell me the food was good. She would be afraid I would feel guilty.

I think there are an awful lot of evil sons and daughters like me who would dump ma in the nursing home the minute they had a chance, and our usage would go up. I am not talking about people who are sick; just people who would eat better.

If I am not mistaken, half of the single women in this country live on Social Security alone. That averages $500 if they are white, and $400 if they are black.

Tell me where they will stay for that kind of money? They live now, God knows how, on it. There isn't a nursing home in California for less than $1,500 a month, I don't suspect.

Mr. WILLGING. I think that is a problem. I represent nursing homes. I am proud of the homes I do represent. I think——

Chairman STARK. Do you represent anywhere you could put somebody for less than $1,500 a month?

Mr. WILLGING. Very few.

Chairman STARK. I think they are necessary; they are well run. I don't think the Federal Government can afford to pay for nursing care. Your prices would go up. There would be such a crunch on

the number of facilities available. That is a reasonable reaction from a business enterprise.

I am just suggesting that that has never been intended to be part of Medicare. I think people believe that. I think we really do the world a disservice if we don't disabuse them.

Mr. WILLGING. You cannot criticize Medicare for being untrue to its legislative design. It was designed only as an extended stay treatment modality, posthospital.

I think, however—and I am obviously parochial—but I do believe that the country does have to ask itself what is the most appropriate mechanism for dealing with chronic, long-term needs, which as my colleague suggests are something we didn't worry about 20 years ago, because we weren't keeping people alive as well as we are today.

Chairman STARK. We are not willing to deal with triage, and other issues, because they are not part of our philosophical makeup.

I think you are right. I think that ought to go to Henry Waxman's committee, however.

Mr. WILLGING. We are going to deal with it on the Secretary's Advisory Commission, Mr. Chairman.

Chairman STARK. I thought we were going to deal with catastrophic medical care.

Mr. WILLGING. No, not if I can help it.

Chairman STARK. The catastrophies of life may be beyond our chart.

Mr. WILLGING. Think of the challenge.

Chairman STARK. You have been very kind and patient. I appreciate your support. I will look forward, as I know my colleagues will, to your constructive criticism as we try to craft a bill that will make some improvement in the quality of care for beneficiaries, and give some guidance to those people who, I think in good faith and good spirit, are trying to make the system work efficiently and fairly.

Thank you all.

We will have some further questions from the staff. We look forward to your written responses.

The hearing is adjourned.

[Whereupon, at 1:45 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

by the

AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and members of the Committee, the American Association of Homes for the Aging (AAHA) appreciates the opportunity to submit testimony on H.R. 4638, The Medicare Quality Protection Act of 1986. We commend your efforts to maintain quality in the Medicare program at a time when concern for budget deficit reductions threatens to undermine the integrity of this health care program for the elderly.

Many of the provisions of H.R. 4638 will directly affect the members of our association. Those members represent approximately 2,000 nonprofit facilities which provide housing, health care, and community services daily to more than 500,000 elderly individuals nationwide. Over 75 percent of AAHA members are affiliated with religious organizations. The remaining members are sponsored by private foundations, government agencies, unions, fraternal organizations, and community groups.

AAHA strongly supports the sections of this bill which would promote quality hospital and post-hospital care and enhance access by Medicare patients to long term care, when that care is necessary. We particularly support provisions which would discourage premature hospital discharge and which would require discharge planning as a condition of participation. We believe that both of these provisions would increase the likelihood that patients are stabilized before leaving the acute care hospital setting. We also believe these provisions would lessen the unpredictability of post-hospital placements for both the beneficiaries and the providers of post-hospital [illegible]

In addition, AAHA believes that there are several propos[illegible] H. 4638 which present enormous potential to further the quality goals o[illegible] legislation. We would like to comment on these provisions specifically [illegible] suggestions for clarification and/or extension of the ide[illegible]th.

1. The Study of Administratively Necessary Days

AAHA supports Section 186 of the bill which would require th[illegible]etary of the Department of Health and Human Services to study the reinstit[illegible]on of separate payments for administratively necessary days (ANDs). We particularly endorse the requirements that the Secretary consider the impact of shortages of post-hospital skilled nursing beds, the risk of discharge to inappropriate institutions, and the administrative mechanisms which can be used to prevent inappropriate payments for ANDs.

AAHA does not support the implementation of separate payments for ANDs without further study, because we believe that such a plan would perpetuate a short-term solution to what has become, and will continue to be, a chronic problem in long term care. There remain too many "unknowns" to justify the implementation of separate payments without a deeper understanding of the problem they purport to alleviate.

The concept of administratively necessary days is similar in some ways to that of swing beds. Both plans reimburse hospitals for providing long term care to patients for whom acute care is not needed but for whom skilled nursing beds are unavailable. The swing bed program assists small rural hospitals; the AND approach does not list specific criteria for a hospital's participation.

For either the swing bed or AND approach to operate, two economic forces must be present: 1) there must be at least a temporary shortage of skilled nursing beds, and 2) there must exist hospitals with low occupancy rates. The existence of both forces in the current marketplace has been well-documented. Although proponents of swing bed/AND reimbursement mechanisms tend to focus on the SNF bed shortage part of the equation, the other, inescapable, implication of these reimbursement approaches is that many hospitals, particularly those in small communities, are having severe financial problems and require some type of federal assistance.

This assistance is not in itself objectionable and, in fact, is a positive development in many cases. No organization with Medicare beneficiary interests at heart would advocate a modification in the reimbursement system which undermined the role of the community hospital. The community hospital is,

after all, the source of acute care for many of our elderly, as well as the rest of our population. Moreover, the community hospital is frequently the resource on which long term care facilities rely when their residents become acutely ill.

However, while we can support swing bed/AHD measures as a short-term, stop-gap means to compensate for the shortage of skilled nursing beds, we part company with proponents of these measures who view them as long range solutions. At some point in the very near future, hospitals must find more appropriate ways to deal with their budget problems, and legislators must accept the need for construction of additional skilled nursing facilities. This will entail the revamping of a regulatory scheme which has systematically erected barriers to the construction of new facilities, such as severe Certificate of Need restrictions. This is not an easy task, but to do less is to send a message to the elderly of this country that we consider the benefits to hospitals to be more important than the costs to patients.

The patient "costs" we refer to are real and have several dimensions. Initially, research findings presented at a recent swing bed conference sponsored by the Robert Wood Johnson Foundation indicated that although long term care provided by hospitals is cheaper for short stays, the care becomes more expensive over time, if compared with the cost of nursing home services. Second, the type of geriatric functional assessment required to understand an individual's long term care needs is not generally completed by physicians and nurses in acute care settings. As a result, the individual attention needed to preserve an elderly person's independence (to the extent possible) may be sacrificed to the regimen necessary for the efficient management of an acute care hospital. Third, quality of life concerns for most residents (food, staff attitudes, activities, access to outside visitors, etc.), are not those best met in a highly technical, acute care setting.[1] There is nothing to indicate that the experiences of swing beds and AHDs would be different.

Our concerns over the potential for extensive lengths of stay under the AHD mechanism are based on the following relevant facts: 1) hospital occupancy rates are continuing to decline and this trend shows no tendency to reverse itself; 2) many states now have a moritorium on nursing home bed construction, and pressures to keep Medicaid spending under control make it unlikely that those moritoria will be lifted anytime in the near future; and 3) according to 1983 U.S. Bureau of Census projections, the actual numbers of elderly will continue to rise rapidly. Between the years 1980 and 2000 (just 14 years from now), the number of elderly 85 years and older will more than double from 2,240,000 to 5,136,000.[2] This age group has the highest nursing home utilization rates of any group in our population.

AAHA's concern is that these factors will come together with the "kill two birds with one stone" philosophy and point the way to long term residence of the elderly in acute care hospitals, facilities which are not equipped, or disposed, to meet the needs of the institutionalized aged.

We raise these points in connection with the proposed study because we believe that the time to start dealing with this issue is before it hits crisis proportions. The way to approach the issue is to develop a body of information which will define the parameters of the problems, identify possible solutions, and remove the barriers to those solutions. We have come to the point where anecdotes are no longer acceptable substitutes for data. We are also at a stage where any study which manages to be funded and conducted should be developed to yield the greatest amount of information possible.

AAHA believes that the proposed study of AHDs is a strong vehicle to begin gathering the information we need to plan for the long term needs of our growing elderly population. Specifically, we encourage the Committee to broaden the scope of the study to look at the methods hospitals use to identify the availability of alternative long term care services before relying on AHDs;

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[1] Swing-Beds: "Experience and Future Directions," sponsored by the Robert Wood Johnson Foundation and held at the Brookings Institution, February 24, 1986. Proceeding will be published in late summer, 1986.

[2] Cited in "Health Care Needs of the Elderly," by Dorothy P. Rice, appearing in Long Term Care of the Elderly, Harrington, Charlene, et. al, eds., Sage Publications, Beverly Hills, California (1985).

to develop at least minimum standards and guidelines for documentation of the unavailability of skilled nursing beds; to identify the average length of stays in acute care hospitals which are characterized as administratively necessary days; to determine the number of patients and hospitals involved; to identify the geographic fluctuation (both by region and urban/rural) in AND utilization; to ascertain patterns, if any, of specific DRG classifications which appear to require ANDs; and to establish the degree to which the use of ANDs provides evidence of a short-term or chronic shortage of skilled long term care beds.

Additionally, AAHA recommends that the language of Section 186 (c)(1)(A), "Considerations in Conducting Study", be clarified. As now constructed, that section reads:

> [the Secretary shall consider the need for such a payment in order to minimize]
>
> (A) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care.... (Emphasis added.)

We were unable to determine the meaning of the underlined phrase or its relationship to the rest of the paragraph.

2. Extension of the Waiver of Liability

AAHA appreciates the Committee's proposals to strengthen the waiver of liability for both skilled nursing facilities and home health agencies. We strongly support the provision which states that if SNFs or HHAs request a reconsideration of a denied claim, the favorable presumption would remain in effect pending the outcome of an expedited review determination. Similarly, we favor the provision which would permit providers to appeal adverse coverage decisions on behalf of beneficiaries.

In addition, AAHA agrees that the waiver should be extended to cover HHA technical denials. However, we believe, that to have meaning, the new HHA waiver provisions should be accompanied by a return to the five percent claims denial threshold, rather than the 2.5 percent threshold under current law. If the 2.5 percent threshold remains, increasing the categories of claims which can be counted against the waiver will result in HHA waivers being lost more readily. The enhanced predictability of claims approval which the Committee intended to achieve by this provision would effectively be lost.

3. Development of a Uniform Needs Assessment Instrument

AAHA supports a uniform needs assessment instrument as a worthy goal but encourages the Committee to recognize past experience in this area. One of the most recent attempts to develop such a document was the PACE project, which resulted in a 48-page form. Use of the form never became a requirement because by the end of its development, it was generally considered unworkable.

In addition to past difficulties involved with this type of instrument, AAHA believes clarification is necessary regarding part (a)(1)(C) of Section 284.

That section now reads:

> [The Secretary shall develop a uniform need assessment instrument that...evaluates]
>
> (C) the social and familial resources available to the individual to meet those requirements;

Currently, this language is not in the law which sets out criteria for determining whether skilled nursing care is needed and reimbursable. Section 1814 of the Social Security Act provides that Medicare will make payment for services that—

> (B) in the case of post hospital extended care services, such services are or were required to be given because the

> individual needs or needed on a daily basis skilled nursing care...which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis....

It is unclear whether the proposed language sets out new criteria for evaluating the need for SNF care or is intended to amplify the "practical matter" requirement. AAHA believes that this language has the potential to be a positive step in recognizing the factors which contribute to the need for post-hospital care. However, we are concerned that the language could also be turned around to exclude some elderly from skilled nursing care, even when they meet the qualifications set out in current law.

4. Expand the Role of the Peer Review Organizations (PROs)

AAHA includes under this heading all the bill's provisions to expand PRO review and sanction authority. AAHA is concerned about the expanded role of the PROs for several reasons.

Initially, with reference to Section 328 of the bill (Requiring PRO Review of Quality of Care), we question how "potential problems of quality" will be identified and dealt with in ways which differ from methods already employed by state inspection teams, federal look-behind study teams, and long term care ombudsmen. Besides the fact that these individuals and groups will be falling over each other searching for poor quality, we question whether the PROs traditional orientation to a medical model of review (for use in acute care settings) is the most appropriate review mode for long term care. It appears to us that medical review, supplemented with a long term care perspective, is required of the new long term care survey process, now being implemented by the Health Care Financing Administration with cooperation of state agencies. This survey process will include the failure to provide necessary services. AAHA believes that the new patient survey process should be allowed to get underway before another layer of review is added.

With regard to the PROs' new assignment to investigate all written complaints made by beneficiaries or their representatives, we support providing a confidential outlet for beneficiary complaints; however, we are not clear as to how the proposed complaint system will mesh with the ombudsman program under the Older Americans Act. Since it is contemplated that increased funding for PROs would be involved with this expanded scope of work, it might be more economical to put those funds into better training for ombudsmen, rather than to initiate a new, and probably overlapping, investigation system.

5. Study of Long-Term Quality Assurance and Review Strategy

The Association supports this study. Although we recognize that it may overlap with the recent Institute of Medicine effort, AAHA was disappointed that reimbursement was beyond the scope of the IOM study and would welcome any analytical work which will link the IOM findings to reimbursement issues.

The connection between quality and reimbursement has been dismissed by many researchers as "too complicated" to be included within the same study. There is no dispute that the issues are complicated. However, the federal government expects providers and beneficiaries to deal with these complications every day in situations which are a great deal less dispassionate than the research setting. AAHA thanks the Committee for seeking to have the Department of Health and Human Services address this difficult but essential issue.

In closing, we want to reiterate the Association's appreciation for the Committee's efforts to uphold the quality of the Medicare program. H.R. 4638 clearly reflects an approach which seeks to address some frustrating provider issues, while maintaining a sensitivity to the needs of this country's 32 million Medicare beneficiaries. AAHA looks forward to working with the Committee as the bill proceeds through the legislative process.

STATEMENT

OF THE

THE AMERICAN FEDERATION OF HOME HEALTH AGENCIES

## INTRODUCTION

In the wake of a steady stream of regulatory changes issuing from the Health Care Financing Administration, the home health benefit has entered a period of great uncertainty. We are led to wonder if those in charge of the Medicare program are serious about providing health services to homebound beneficiaries. There is presently an urgent need for Congressional action to stabilize the home health benefit before any further disruption is added to the recent litany of regulatory changes and additional paperwork requirements imposed upon home health agencies. We need a moratorium on any further regulatory proposals from HCFA until we can adjust to the policies of our new fiscal intermediaries and to the numerous changes thrust upon us in the last year or so. At the same time, some HCFA actions must be reversed if home health services are to remain available to all disabled and elderly Americans who need them. The Medicare Quality Protection Act of 1986 would reverse several of the most detrimental changes which have had an impact on the ability of home health agencies to provide care to Medicare beneficiaries.

The American Federation of Home Health Agencies, which represents Medicare certified home health agencies throughout the nation, strongly supports the Medicare Quality Protection Act of 1986 (H.R.4638). We are particularly pleased that this legislation addresses the issues of provider representation of the beneficiary in the appeals process and waiver of liability.

## PROVIDER REPRESENTATION OF THE BENEFICIARY

From the inception of the Medicare program, health care providers served as representatives of beneficiaries in the appeals process. In January, 1984, however, HCFA issued a directive prohibiting providers or their employees from representing beneficiaries whose services have been denied. We believe that this HCFA policy is based on spurious reasoning, violates the intent of Congress, and serves to deprive elderly and disabled Americans of benefits to which they are entitled.

We believe that the prohibition against provider representation of beneficiaries is but one piece of a whole pattern of policies implemented by HCFA to cut costs, at the expense of quality and access to care. The bottom line has become the only line.

AFHHA has looked at Medicare law and regulations and we can find nothing that precludes provider representation of the beneficiary in the appeals process. (Reference Sec.206(a) and 1879(d) of the Social Security Act and Social Security regulations at 20 CFR 404.1705(b), 404.1707, and 404.1710.) Section 404.1705 in particular describes who may be appointed as a representative for hearings and appeals, and states that a person who is not an attorney may be designated if he or she is of good character and reputation; is capable of giving valuable help; is not disqualified from acting as a representative; and is not prohibited by law from acting as a representative. We have raised these points with HCFA and have been told: "We believe there is sufficient authority in the statute, regulations, and formal program instructions to deny an HHA the right to represent a beneficiary in pursuing an appeal under the Medicare program."

In precluding provider representation, it appears that HCFA officials decided upon the result they wished to achieve, then looked around for words to justify their end. The result is HCFA's contorted justification, as found in Revision 1079 of the Fiscal Intermediary Manual (HIM-13). One argument is as follows: "HCFA is concerned that permitting providers to act as the beneficiary's representative is of dubious value to the beneficiary because the provider cannot act as a qualified representative."

We must ask who could be more qualified to represent a beneficiary than an employee of an agency who has rendered care to the patient, is familiar with the details of the case, and has experience with the appeals process. Many patients receiving denials are extremely ill and confused; often the beneficiary

lives alone or with a spouse equally debilitated. Even if there are competent family members or friends available and willing to assist in the appeal, the process is daunting to a layperson with no appeals experience. To pursue an appeal, beneficiaries face the formidable tasks of filling out the proper forms in a timely manner, developing arguments to contest the denial, and collecting evidence to support the case. In the absence of representation by family, friends, or HHA personnel, a beneficiary could turn to a lawyer; however few debilitated beneficiaries can afford the services of a private attorney.

Revision 1079 also states: "There is a question of a conflict of interest between a provider and a beneficiary because of the provider's interest in protecting its favorable waiver of liability presumption or appealing a coverage determination."

AFHHA believes that the facts are quite the opposite. Beneficiaries are never harmed by a successful appeal which allows them to continue to receive services. There is no conflict between the interest of the provider and the interest of the beneficiary in appealing a denial. If a provider is successful and is therefore able to retain waiver of liability, the provider benefits; the patient equally benefits since by reversing the denial, the HHA is able to continue services that would otherwise be disallowed. If an HHA does not encourage a patient to contest a denial, even though paid under waiver, the beneficiary is on notice that similar services will be denied in the future. When an agency retains waiver of liability, it is in a much better position to continue providing services in the grey areas without fear of not being reimbursed.

The following is an example of the type of case that is being brought to our attention: An 86 year old woman living in a southern state suffered from Alzheimer's disease, leg contractures, a series of mild strokes, anemia, anorexia, bronchitis, skin ulcers, acute urinary tract infection, and urinary and bowel incontinence. She was an extremely weak, confused, totally dependent patient who lived alone. Her two children took turns stopping by. Her condition deteriorated, and she had to be readmitted to the hospital. What this elderly woman got from Medicare was denial of all of her home health care on the claim that skilled nursing care was no longer needed. The services provided were covered under waiver of liability, but the patient was put on notice that all visits of the same type would be denied in the future.

Beneficiaries as old, sick and debilitated as this woman are not in a position to mount an effective appeal against a massive Federal bureaucracy. Intermediaries are fairly safe in making denials on the most seriously ill and vulnerable patients, since there is not much chance of the beneficiary fighting back aggressively, especially without representation by the HHA nurse who knows the patient and system best.

We believe that HCFA's prohibition was precipitated by the very success of providers representing beneficiaries in the appeals process. Those with the most knowledge of the case and the process are banned because they have demonstrated their effectiveness.

The refusal to allow home health personnel to represent the beneficiary coincides with a significant upsurge in denials. We believe HCFA's plan is to encourage denials, with the knowledge that only a percentage will be contested. If FIs are not held accountable for their own errors, as more HHAs experience arbitrary denials and become familiar with the appeals process, the bottom line will reflect phantom savings, consumed in part by the cost of appeals and adjudication. And the cost in human terms is beyond calculation. Some beneficiaries will go without care and others will be subjected to needless institutionalization.

## WAIVER OF LIABILITY

HCFA issued final regulations on February 21, 1986, to eliminate the favorable waiver of liability protection for home health agencies, skilled nursing facilities, and hospitals, effective March 24, 1986. The Reconciliation legislation passed by Congress in March provides for continuation of the waiver presumption

for home health agencies until one year after the ten regional fiscal intermediaries begin operations.

Home health agencies are cost reimbursed. They have limited capital resources to fund visits not covered under waiver of liability. The uncertainty of the current climate makes waiver protection all the more crucial. HCFA now proposes to hold HHAs to a one hundred percent standard of accuracy, while acknowledging a 32.4 percent rate of reversal on appeal for HHA denials. Agencies all over the country are receiving inconsistent and unclear directives from intermediaries. The majority of HHAs will be transferred to new FIs in FY'87, exacerbating the denial problem for providers trying to adapt to the policies of a new intermediary. With the continuing budget restraints flowing from budget considerations and from the dictates of the Gramm-Rudman-Hollings legislation, leading in part to a reduction in the ability of intermediaries to process claims in a timely manner, loss of waiver would lead to considerable disruption of agency operations.

For these reasons, AFHHA strongly objects to HCFA's attempts to eliminate the favorable waiver protection found under Section 1879 of the Medicare law. Section 1879 was enacted as part of the 1972 amendments to the Social Security Act. Prior to its enactment, providers of services were faced with a real crisis that led Numerous small providers, particularly small home health agencies, to close down their operations. This happened because absent this provision, providers could in good faith incur expenses to provide services, only to have Medicare retrospectively deny the bills for the services furnished. A provider's only recourse was to attempt to collect from the patient, but because of the economic circumstances facing most of the elderly, this was a most unsatisfactory situation. Obviously, neither home health agencies nor any other providers can for any length of time pay salaries and purchase supplies to provide services for which they will not be paid.

Responding to this dilemma, Congress enacted the waiver of liability provision, which provides that when services furnished are determined by the fiscal intermediary to be not covered, but neither the patient nor the provider knew or reasonably could have been expected to know the services were not covered, the government would accept liability and reimburse the provider. This eminently fair and reasonable provision solved the retroactive denial problem in practically all cases and enabled providers to furnish services with confidence in obtaining reimbursement.

We believe that there are misunderstandings about the financial exposure of the U.S. Government under the waiver of liability provision. Waiver does not result in Medicare being liable for extensive amounts of non-covered services. There are very close controls and limitations. To qualify for the protection afforded, a provider must demonstrate a thorough understanding of Medicare coverage criteria. It can demonstrate such understanding if, in the case of a home health agency, its denial rate does not exceed 2.5 percent of all visits billed. Moreover, intermediaries re-evaluate each provider at least every three months. Whenever a home health agency's denial experience exceeds 2.5 percent for a quarter, it no longer qualifies for waiver status. It can qualify again only after it is able to demonstrate knowledge of the coverage criteria by having a 2.5 percent denial rate or less. Even where the provider has limited liability status, it must still demonstrate it did not know or could not have been expected to know that the services it furnished were not covered. Where the provider demonstrates lack of knowledge, it cannot be reimbursed for subsequent billings for the same services; once payment is made under this provision, the provider has notice that the services are not covered. Without this protection, home health agencies and other providers of services may not receive reimbursement for a number of cases that require a fine judgment by the provider and the intermediary on whether the Medicare level of care requirements are met. A provider can now furnish services on these cases, under waiver of liability, immediately upon receipt of a physician's orders. Not knowing if reimbursement would be made, providers will have to delay offering these services, to the disadvantage of the patient, until the intermediary can furnish them with a coverage decision. In addition, different intermediaries frequently reach differing decisions on these cases, depending on all of the factors present. Many refuse to render a judgment at all before a claim is filed, and there are no general

criteria that home health agencies can follow.

The favorable waiver of liability presumption has worked well since its enactment in 1972. Its loss would put providers at much greater risk, lead them to limit the services they can offer to many beneficiaries, and turn the clock back fourteen years to a time when providers were faced with sizeable amounts of non-recoverable funds for services rendered in good faith.

The American Federation of Home Health Agencies urges the prompt passage of the Medicare Quality Protection Act of 1986. Enactment of this legislation, with its beneficiary representation and waiver of liability provisions, will return some semblance of balance and equity to the Medicare system, and protect the rights of older and disabled Americans to receive the home health services to which they are entitled.

American Physical Therapy Association
1111 North Fairfax Street
Alexandria, Virginia 22314

177

May 9, 1986

The Honorable Fortney H. Stark
Chairman, Ways and Means Health Subcommittee
1114 Longworth House Office Building
Washington, D.C. 20515

Attn: Joseph K. Dowley, Esq.
Chief Counsel
Committee on Ways and Means
1102 Longworth House Office Building

Dear Chairman Stark:

The American Physical Therapy Association is pleased to submit this statement for the record in support of H.R. 4638, the Medicare Quality Protection Act of 1986. The American Physical Therapy Association represents over 40,000 physical therapists, physical therapist assistants, and physical therapy students. We believe that the Act would provide some valuable safeguards to ensure that our nation's Medicare beneficiaries receive the highest quality services possible both in hospital and in outpatient settings. We would like to offer some brief comments on the provisions of H.R. 4638 which are of particular relevance to physical therapists and physical therapy patients.

We strongly support the permanent reinstatement of the favorable waiver of liability presumption for home health agencies and skilled nursing facilities. While we are appreciative of the temporary extension of the waiver provisions granted to home health agencies and nursing homes under the Consolidated Omnibus Budget Reconciliation Act of 1985, a permanent extension is necessary. As patients continue to be discharged "sicker and quicker" under the DRG system, the need for skilled nursing, home care, and other types of post-hospital care will continue to increase. While cost-shifting is of obvious concern, it seems a misguided and even perverse remedy to penalize those providers onto whom the burden has been shifted.

The Health Care Financing Administration, in its rule eliminating the waiver, emphasized that major concerns to be addressed are instances in which care is being provided which is not medically reasonable and necessary or which is characterized as custodial care. Yet, despite all assumptions to the contrary, such instances are not universally agreed upon by the intermediaries themselves, nor are they generally known to the providers.

Most importantly, elimination of the presumption would result in an early curtailment of services to Medicare beneficiaries. Despite the fact that beneficiaries have been found to be in need of more services and a greater intensity of services, providers will be given the clear signal that early termination is the more appropriate course to take.

We are pleased that the legislation proposes to extend waiver of liability coverage to denials based on "homebound" and "intermittent care" requirements. However, we echo the testimony of the National Association for Home Care, which noted before your Subcommittee that the 2.5 percent threshold would need to be adjusted upward in order to account for the addition of these claims into the base used for computation. We request that the level be raised to 5 percent, equivalent to the level of denials allowed for skilled nursing facilities.

We are also pleased that the legislation mandates the Secretary to develop a uniform needs assessment instrument to determine an individual's post-hospital needs. The implementation of the DRG system has fundamentally altered the level of intensity of post-hospital services required for many patients. It is vital that a fresh look be taken at the issue of need and scope of services to be delivered.

We strongly agree with the National Association for Home Care that "probably the biggest problems facing home health agencies at present concern widespread, extensive delays in the time it takes to receive payment or a coverage determination after the claims have been submitted." Many physical therapists own or administer home health agencies and have reported that such delays have greatly increased over the last several months. These small business people cannot afford the long delays which have become the norm in many cases. Further, when coverage decisions are delayed, it forces the provider to choose between continuing to provide services with no certainty that they will ever be reimbursed, or terminating the provision of needed services to the beneficiary.

Finally, we are pleased that H.R. 4638 would once again allow Medicare beneficiaries to appoint a provider or supplier to represent them in the claims denial process. Our members stand ready and willing to represent Medicare beneficiaries in their appeals, yet the stance of the Health Care Financing Administration precludes this assistance from being accepted. This is especially problematic because it is these very providers and suppliers who could be most effective as the representatives of the beneficiaries in the appeals process. After all, the services denied coverage were rendered by these providers and suppliers. The enactment of H.R. 4638 would eliminate this major inequity in the current appeals process.

On behalf of our members, the American Physical Therapy Association thanks the Chairman for this opportunity to present our comments.

American Speech-Language-Hearing Association
10801 Rockville Pike • Rockville, Maryland 20852 • (301) 897-5700 (Voice or TTY)

May 6, 1986

Joseph K. Dowley
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

The American Speech-Language-Hearing Association (ASHA) supports H.R. 4638, the Medicare Quality Protection Act of 1986. Our 47,000 members provide services to the communicatively impaired in a variety of settings, many of which are Medicare certified providers. Speech-language pathologists and audiologists render services in hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, comprehensive outpatient rehabilitation facilities and hospices. We have received reports of continual problems created by the prospective patient system (PPS), most of which are addressed in H.R. 4638.

The section of the legislation which would require the Department of Health and Human Services to amend PPS so that severity can be accounted for is particularly applicable to rehabilitation patients who are treated by speech-language pathologists. These patients may not be admitted to an exempt hospital or unit but still require intensive rehabilitation. The current structure of PPS does not account for these patients and they are either not rehabilitated as inpatients or receive minimal services in some instances.

ASHA recommends that the waiver of liability be extended to rehabilitation facilities as well as home health agencies and skilled nursing facilities. The notion of HHS that providers now understand the coverage decisions of fiscal intermediaries is not supported by documentation. Speech-language pathologists in rehabilitation agencies evaluate and treat patients in good faith only to have denials made on unsupportable grounds. Appeal of these denials is often successful but very expensive for the provider.

ASHA concurs with the American Nurses Association that peers should review the activities of peers. Currently, only physicians are given the responsibility for review in the Peer Review Organizations. If the PRO is or is not extended beyond the PPS inpatient hospital services, peer review should be extended to all health professionals providing services. Therefore, an addition should be made to the PRO section on page 29 that adds a Section 306 and states Peer Review Activities by Practitioners Other Than Physicians.

(a) Section 1154(a)(5) of the Social Security Act (42 U.S.C. 1320c-3) is amended at the end by adding, "Nurses, rehabilitation professionals and other health care practitioners shall also be responsible for final peer denial determinations of the services of their peers."

The Medicare Quality Protection Act of 1986 is an important step in reinstating the proper design of Medicare for patient care. The American Speech-Language-Hearing Association believes that the rehabilitation of patients both in hospitals and in other provider settings will be improved with the placement of this legislation into law.

Sincerely yours,

Steven C. White

Steven C. White, Ph.D.
Director
Reimbursement Policy Division

California Hospital Association
1023 12th Street P.O. Box 1100 Sacramento, CA 95805-1100 916/443-7401

April 18, 1986

Honorable Fortney Stark
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Stark:

On behalf of the California Hospital Association, I would like to take this opportunity to comment on the advance draft of the Heinz-Stark Quality Assurance Act. As an overview, we would like to express our complete support for the comments raised by the American Hospital Association in its April 4 letter. There are a few points, however, we would like to emphasize:

1. Development of a legislative proposal to refine the PPS patient classification - Like AHA, CHA, since the inception of the prospective payment system, has encouraged and supported Congressional efforts to refine PPS in order to eliminate the current equity distortions. We have now focused our emphasis on the issues of intensity, severity and the non-labor component of the PPS price. We have endorsed and supported the AHA's efforts to refine the outlier payment policies to better reflect the differences within various DRGs. The increase in budgetary pressures on the Medicare system will make such modifications even more important. We will continue to work with you and your staff to more fully develop these issues.

2. Continued stay appeals - The CHA supports efforts to expedite PRO decisions on appeals of continued stay denials. It is critically important for hospitals' financial situation that such PRO determinations be made as rapidly as possible. We would hope that this legislation would help to deflect the efforts by the Administration to arbitrarily limit hospital payment under Medicaid for administrative days of care.

3. Administratively necessary days (ANDs) - CHA has always supported the concept of administratively necessary days where hospitals would be paid for post-acute treatment at an appropriate rate. In an effort to maintain overall quality of care for all patients, it is increasingly important that there be a smooth transition from inpatient to post-acute care. In 1985, the long-term care nursing homes in California had over a 95-percent occupancy and were unable or unwilling to accept Medicare transfers. This has an especially adverse fiscal impact upon hospitals when they cannot place or transfer patients who no longer need acute care stays but rather are forced to keep them, thus causing hospitals to assume unnecessary additional costs. We believe that administratively necessary days would lead to better continuity of care for patients needing post-acute care or such care as unavailable in the community. We also feel that an expansion of the swing bed program would further the same end.

We welcome this opportunity to share these concerns with you. As we noted above, we support the AHA's comments and pledge our support and willingness to work with you in addressing these issues. We commend you for your enthusiasm and support and to ensure an equitable and orderly development of a very complex system.

Respectfully,

John H. Ferman
Senior Vice President

SAM GEJDENSON
2nd District
Connecticut

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

CHAIRMAN
FOREIGN AFFAIRS
INTERIOR

April 23, 1986

The Hon. Fortney H. Stark, Chairman
Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Pete:

I am glad to have this opportunity to commend you for introducing The Medicare Quality Protection Act of 1986 and for holding this hearing on Medicare Patient Protection. I am particularly pleased that your bill includes a revision of the rules for reviews by the Peer Review Organizations of hospital inpatient discharge notices.

As you know, I introduced The Medicare Discharge Appeals Opportunity Act (HR 4275) on February 27th. My bill would require that PRO reviews be completed during the 48-hour grace period afforded all Medicare patients. I understand that your version gives patients who request a discharge review an additional day of coverage.

I hope that this hearing will examine the probable consequences of both of these approaches in terms of patient protection and cost containment. As you are well aware, under current law Medicare patients can only pursue an appeal if they can afford to pay for one or more days in the hospital if they lose. I understand that by making PRO's respond within two days but allowing a three-day grace period, your bill protects patients who receive a discharge notice too late in the day to request a review before the next morning. I certainly share that concern, but fear that the volume of appeals will increase substantially if Medicare patients can qualify for more coverage by filing an appeal.

I believe that our goals should be to assure that Medicare beneficiaries receive due process regardless of their financial resources and that hospitals are discouraged from issuing premature discharges. Clearly, the lack of a meaningful review opportunity now makes it far too easy for hospitals to shift the costs they should bear to the elderly ill. It is the responsibility of all of us in Congress to assure that pressures for cost containment do not compromise the quality medical care to which senior citizens are entitled. Again, I want to commend you for your leadership on this issue of vital importance to us all.

Sincerely,

SAM GEJDENSON
Member of Congress

**STATEMENT OF**
**FORMER CONGRESSMAN JAMES ROOSEVELT**
**CHAIRMAN OF THE**
**NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE**

My name is James Roosevelt, and I am chairman of the National Committee to Preserve Social Security and Medicare. Mr. Chairman, I want to thank you for this opportunity to comment today on quality health care for older Americans.

I am speaking today on behalf of the over two million active members of my organization who now await decisive Congressional action to address serious deficiencies in our nation's Medicare program.

Over the past three years, we have all come to see the consequences of a health delivery program which devotes itself more to saving costs than healing ills. Almost daily now, National Committee members write me recounting how they or their relatives were discharged from the hospital prematurely. Others report how hospitals skimped on quality care, or how extremely difficult it is to locate needed nursing home or health care arrangements after discharge from the hospital.

These problems persist because there is an inherent conflict of interest between Medicare's cost containment measures and our nation's mission to provide elderly people with the health care they need.

Mr. Chairman, I applaud your diligent efforts and those of Senator Heinz to resolve these problems through the introduction of the Medicare Quality Assurance Act of 1986. My organization appreciated the opportunity to comment on the draft legislation. We commend several major provisions of this bill which would do the following:

- require the Secretary of Health and Human Services to adjust the fixed diagnosis-related groups (DRGs) to accomodate more severe medical conditions
- expand the patient advocacy mission of Peer Review Organization (PROs) so that these boards better monitor quality of care and are more responsive to beneficiary rights
- strengthen the appeals process, so that all patients have to receive written statements of their rights, and cannot be charged during the three-day appeals process
- ease the transition to post-hospital care in nursing homes or home care arrangements by requiring hospitals to have an effective discharge planning process.

The National committee believes that the Medicare Quality Assurance Act is a good first step. But this bill can and should go much further in several key areas.

The basic problems with Medicare prospective payment arise from the DRG system, which pays hospitals a flat fee for set procedures rather than covering individual patients for their charges. This system encourages hospitals to reduce care in order to make higher profits. Some experts concur that merely fine-tuning prospective payment rates will sufficiently alter the forces undermining quality care.

AUG 1986

Fine-tuning the current system, however, may not be the panacea some believe. I urge Congress and other advocates for the elderly to continue to look hard at alternatives to prospective payment which address more fundamental solutions. We must ensure that a cost-effective Medicare payment system is based on the needs of each individual, rather than on some bureaucratic formula.

Until these basic problems with prospective payment are ironed out, Congress has foremost responsibility to protect older people from falling through the cracks in this system.

We believe that protection for the elderly under the Medicare Quality Assurance Act stops short of fully strengthening patients' rights, the appeals process, and continuity of care.

**Safeguarding Patients' Rights**

The National Committee supports expanding the "watchdog" mission of PROs. We also support extending PRO review and oversight to cover beneficiaries outside the hospital -- both in nursing homes and in home-health arrangements. PROs need to devote at least as much of their time and resources to monitoring quality of care as they now do to finding ways to shave costs. The Medicare Quality Assurance Act should do more than just stipulate that a "reasonable proportion of its activities" is devoted to quality care review, as the bill proposes. It should actually require that half of PRO resources is devoted to such activities.

**Creating a Workable Appeals Process**

The National Committee believes that it is of crucial importance that Congress approve an appeals process that gives elderly patients quick and easy access to the system without any financial penalties. We know by experience that elderly, frail people -- who may be confused and frightened by their illness -- do not find it easy to follow through on a complex, bureaucratic appeals process.

We have been urging Congress to create a PRO hot-line for Medicare patients to appeal admission, discharge or post-hospital problems. To work effectively, the hot-line should give beneficiaries continuous access to the PROs seven days a week.

Medicare has finally agreed to provide beneficiaries with a statement of patients' rights when they enter the hospital. This information must also be mailed directly to beneficiaries with their annual notices. These notices should include a sticker with the phone number of the local PRO that beneficiaries can attach to their Medicare card.

Some Medicare hospital patients will need more help to secure their appeal rights than this bill provides. This is especially true of patients temporarily incapacitated by illness who live alone. In these cases, the intervention of a patient advocate or hospital ombudsman may be necessary to make certain that the patient receives all needed care. I urge your Committee to consider this suggestion.

Any appeals process that Congress eventually backs must make the "nuts and bolts" of this appeals process absolutely simple. No matter how well-conceived the appeals process proposed by the Medicare Quality Assurance Act, it does no good if elderly people

can't negotiate it. Making this appeals process virtually seamless is crucial for older people who are very ill but whose "DRGs have run out."

Promoting Continuity of Care

The National Committee is also concerned that there is not an adequate infrastructure in place to care for older Americans who are leaving the hospital much less ambulatory than ever before. Sound discharge planning is of utmost importance when hospitals are releasing patients early.

We need to work much harder to develop better hospital discharge planning. Sometimes the concern is finding an opening in a nearby nursing home -- not always an easy task. Sometimes the job involves co-ordinating nurses and aides at home. We have all heard of cases of old people unable to walk who are discharged to their second or third floor apartments, where they have to cope' alone.

We suspect that discharge planning is such a difficult task at this point because of the lack of co-ordinated post-hospital options for older patients still needing care. Medicare beneficiaries now more than ever need a continuum of care that extends beyond the hospital. We urge your Committee to spell out in more detail how this crucial discharge planning process would work.

Thank you for your consideration.

April 23, 1986

Edward R. Roybal
EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

**STATEMENT**

before the
HEALTH SUBCOMMITTEE OF THE COMMITTEE ON WAYS AND MEANS
10:00 a.m., April 23, 1986
B-318 Rayburn House Office Building, Washington, D.C.

Mr. Chairman. As you know, the House Aging Committee has been fighting hard these past two years to preserve Medicare beneficiaries' access to quality health care. As a result of a series of hearings beginning in February 1985, I introduced and have pushed two major Medicare quality and access bills -- H.R. 1970 and H.R.4330. (See attached summary of H.R. 4330.) I am extremely pleased to see that many elements of those two bills have been incorporated into your Medicare Quality Protecton Act.

Though there was relatively little interest in quality assurance two years ago, the situation has changed. The Administration has finally admitted that there is reason for concern. They have taken two important steps by strengthening the Peer Review Organizations' scope of work and by notifying beneficiaries of their rights to appeal early discharges.

Today, you and your Subcommittee are taking another major step forward. Your Medicare Quality Protection Act contains many of the quality and beneficiary access provisions contained in my two quality assurance bills, H.R. 1970 and H.R. 4330. For that reason, I am extremely pleased to be an original cosponsor on this important legislation.

However, in the interest of beiter protecting Medicare beneficiaries, I want to recommend several changes that will further strengthen your bill.

- Require at least one-half of PRO resources go for quality assurance.
- Require a PRO consumer advisory board appointed by the Governor.
- Require a 7-day-a-week beneficiary hot-line for quality problems.
- Require a National Council on Quality Assurance to oversee Medicare quality.
- Replace the current Medicare waiver of liability with a prior approval process.
- Build PROs into appeals of nursing home and home health denials.
- Evaluate fiscal intermediaries on accuracy, not just cost savings.

I can assure that my staff stand ready to work with your staff on any further refinements of your bill.

I want to thank you for your continued support of the Medicare program and its many beneficiaries. I want you to know that I look forward to working with you to 1) enact this legislation and 2) better protect health care quality and access for America's 30 million Medicare beneficiaries.

(OVER)

**MEDICARE CONTINUING CARE EQUITY AND QUALITY ASSURANCE ACT OF 1986**
**HR 4330 (CCEQA) - BILL SUMMARY, 4/23/86**

**PURPOSE:** To ensure equity in beneficiary access to quality continuing (long term) health care services and to promote the quality and continuity of care across service settings through reforms in Medicare claims review and appeals procedures, in intermediary performance evaluation criteria and in Medicare's quality assurance system.

**THE ISSUE:** During 1985, the House Select Committee on Aging held hearings on the impact of cost containment on the quality of hospital care and on the beneficiary's access to continuing (long term) care services. These hearings clearly showed that cost containment pressures under Medicare's acute and continuing care benefits are putting the elderly in a "Catch 22" bind -- out sooner and sicker from our hospitals and unable to get the home and skilled nursing care they need now more than ever.

**THE BILL:** The "Continuing Care Equity and Quality Assurance Act of 1986" (CCEQA) is a comprehensive health care reform package that address serious problems of quality and access that beneficiaries now face. CCEQA substantially upgrades the current quality assurance system for hospital and continuing (long term) care and changes the way Medicare's continuing care benefits are managed.

**QUALITY ASSURANCE REFORMS**

- Requires that DHHS award, administer and evaluate its Peer Review Organizations (PRO's) contracts under the stipulation that at least one-half of the PRO's level of effort is for the purpose of quality assurance.
- Requires that DHHS conduct quality assurance activities on all Medicare covered health care providers including hospitals, physician offices, nursing homes, home health agencies, and hospices.
- Requires that PRO's have a 24-hour hot-line to receive questions and complaints from Medicare providers, beneficiaries and others concerning health care quality problems.
- Requires that PRO's have a local Consumer Advisory Board (CAB) which conducts ongoing oversight of the PRO's, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other parties.
- Requires that DHHS prepare reports on the performance of the Medicare quality assurance system, on the impact of DRG's on health care quality, on improved methodologies for quality assessment and assurance in all care settings, and on the feasibility of extending the PRO-based quality assurance system to all payers, all patients and all providers.
- Creates a national council on quality assurance to provide oversight of the PRO system and promote the development of improved methods for measuring and assuring quality.
- Establishes guidelines and standards for hospital discharge planning to prevent premature discharge and ensure a smooth transition to post-hospital care.

**CONTINUING CARE REFORMS**

- Creates national council of continuing (long term) care providers, intermediaries and consumers to make recommendations to the Secretary of DHHS on the implementation of this Act and on other continuing care policies under Medicare and Medicaid.
- Replaces the Medicare waiver of liability with a system of prior and concurrent authorization for continuing care claims that protects the beneficiary's rightful access to Medicare's continuing care benefit and that provides incentives for provider participation.
- Creates uniform assessment criteria for claims review to ensure equity in claim determinations within and across intermediaries and over time.
- Lifts restrictions on beneficiary appeals to make all claims appealable and to permit providers to represent beneficiaries in all cases of appeal.
- Builds PRO review of "medical necessity" and "practical considerations" into the current appeals process for Medicare continuing care benefits.
- Changes performance evaluation standards for fiscal intermediaries to balance incentives for cost savings with accuracy.
- Promotes research in the use of Medicare continuing care benefits in a manner that is cost-effective and most appropriate to beneficiary needs.

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